

THE MANUAL



for
TARGETED INTERVENTION REASEARCH
on
Sexually Transmitted Illnesses
for the Setting of Commercial Sex

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NOTE: The term "sex worker" (frequently abbreviated as SW) has been selected for this document in an attempt to choose a label that is as respectful as possible of the lifestyle of individuals who exchange sex for money, drugs or favors. We recognize that the translation of the term "sex worker" may not be appropriate in all languages or for all situations and that the indigenous social science researcher(s) will need to assess and choose an appropriate term to be used throughout

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Introduction

A. The Importance of Commercial Sex to STD Epidemiology

In recognition of the public health significance of sexually transmitted diseases (STD), governments and health organizations around the world have begun to step up their efforts to prevent and control the spread of these infections. In epidemiologic terms, the aim of such STD control programs is to reduce the incidence (the number of new infections over x time period) of STDs in the susceptible population. This is accomplished by significantly reducing the number of new infections produced in the population by persons who are already infected, specifically by reducing either one or all of the following: (1) the rate of sexual partner change, (2) the probability of infection with each sexual contact, and (3) the duration of infectivity. Following this logic, targeting "core groups" of individuals who have above average rates of sexual partner change and STD infection (including commercial sex workers (SW) and their clients) is central to overall STD prevention and control efforts in a given population.

The research plan presented in this manual represents an important initial step in designing or improving interventions that will have an impact on STD rates in these core high risk behavior groups. It is essentially intended to help program planners better understand and, in turn, programmatically respond to prevalent STD related illness perceptions and treatment behaviors among sex workers and their clients.

B. The Perspective of Individuals in the Setting of Commercial Sex

This Targeted Intervention Research (TIR) instrument is designed to collect information from different types of people who are involved

in commercial sex, including individuals who engage in sexual intercourse in this setting and others who are involved in negotiating the exchange of sex for gifts, favors or money. In addition, the STD clinic encounter is examined in some detail from both the patient and the provider perspective. The research is designed to help program managers understand these individuals' perspectives and behaviors related to sexually transmitted illnesses and Sexually Transmitted Disease (STD) treatment services. This understanding in turn will hopefully be useful in making decisions about how to improve STD service delivery systems, promote appropriate use of these services, and design relevant and effective behavior change messages.

It is important to acknowledge that the STD-related perspectives of individuals involved in commercial sex might be quite different from those of people who have been trained in disease prevention and treatment. It is not enough to have highly trained health professionals, to make high quality services accessible and affordable, and to provide the supplies, drugs, and other items needed to treat and prevent STDs. Medical services and education/communications aspects of the STD Program must be tailored to meet the needs of those served by the Program. For this to happen, program planners must understand the variety of perspectives among individuals involved in commercial sex.

C. What is Targeted Intervention Research (TIR)?

Targeted Intervention Research (TIR) is small scale social science research conducted in response to programmatic needs, in this case STD program design. This TIR utilizes different qualitative and quantitative research methods relying, primarily on semi-structured and open-ended interviews. It is called targeted because it is focused in scope. The research is customized

for each setting starting with a set of programmatic questions set forth at the beginning of the activity. Because of its intended programmatic application, the TIR is designed to be completed in a relatively short period of time and with minimal or no outside technical assistance. While TIR results can immediately be used to improve STD interventions, they also may be used as the basis of representative population- or clinic-based surveys to measure patterns of variability and draw conclusions about larger groups or populations.

While the TIR process and interview Guides focus on programmatic issues related to STDs, the approach and methods could be adapted to many other health programs. Once programmatic questions have been defined, interview Guides can be modified to address the needs of that specific health program.

D. Who is this TIR Manual For?

This Manual is designed to be used by the person responsible for a Sexually Transmitted Disease (STD) Program with an interest in understanding the public health-related perspective of people in the setting of commercial sex. This information can be used to improve the way STD services are delivered. It can be used to develop a communication program that improves both preventive and treatment-seeking behavior while improving patient-provider commu-

nication. The STD Program Manager is assumed to be the principal investigator of and "customer" for this research. This person should have ownership over the process and the results.

The STD Program Manager is expected to use the research results to improve his/her program.

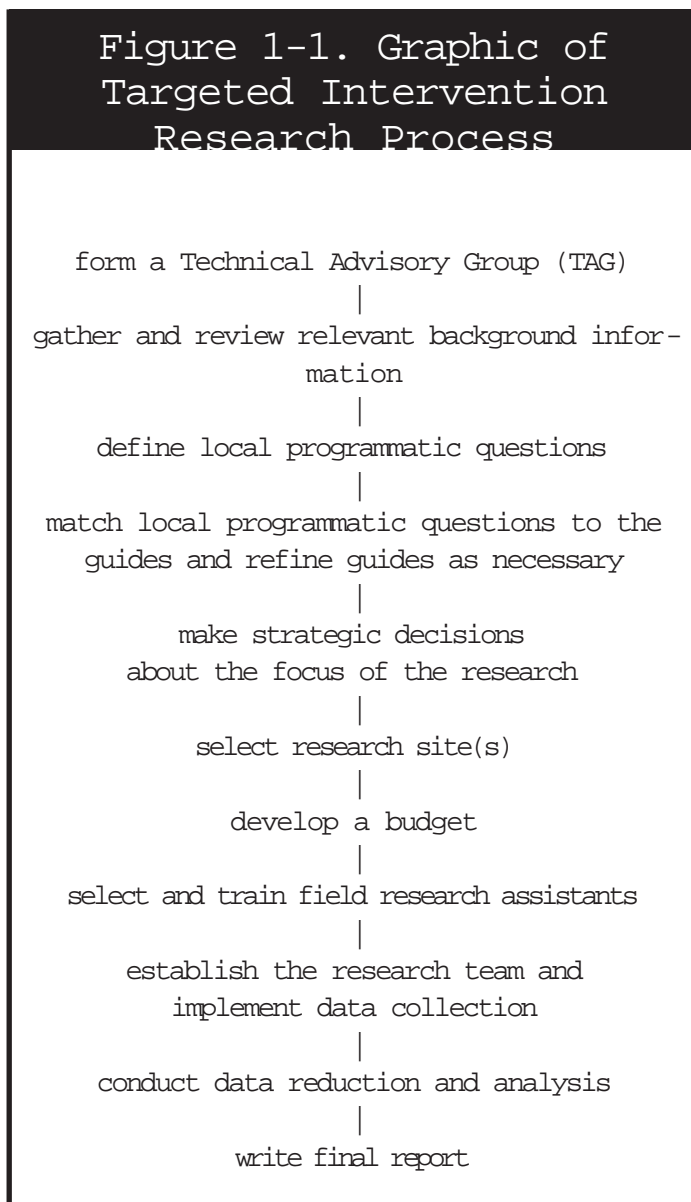
Depending on the circumstances, the STD Program might be within a national Ministry of Health, a state or local health department, a non-governmental organization (NGO), or an institution within the private sector.

In addition to the STD Program Manager, this research activity calls for the participation of a person responsible for the provision of STD medical services (including training and managing STD clinicians), a local communication expert, and a local social science researcher. The local social science researcher, sometimes referred to as the "technical lead", will ultimately oversee the day-to-day implementation of the research.

After the TAG has created a list of programmatic questions

and then compared them with the general list included here (see Section N), the TIR Manual must be distributed to all members of the Technical Advisory Group (TAG). Instead of the complete TIR manual, interviewers only need copies of the Guides for their actual field work assuming the issues of data collection, record-keeping and data analysis are covered in some detail during the interviewer training.

Figure 1-1. Graphic of Targeted Intervention Research Process



E. Overview of the Process

You are about to form a team to collect information about sexually transmitted illness perceptions and experiences among individuals in the setting of commercial sex. This manual will take you through the steps (shown in Figure 1-1) of this research process.

The process begins with you, the STD Program Manager, as the team leader and principal investigator of this effort. You will form a Technical Advisory Group (TAG) including, at a minimum, yourself, a local expert in communication/health education, a local expert in STD clinical services, an objective (non-national) health professional and a social science researcher from a local university. The TAG will help guide the research and assure that its results are used to improve the STD Program. It is assumed that the members of the TAG work as advisors to the STD program. For the TAG members to work effectively, it is important that they are briefed about the STD/HIV epidemiology in your country and the behavioral aspects related to STD/HIV transmission. Therefore, it usually is necessary to gather together a packet of relevant information and distribute it to TAG members prior to the first meeting.

First, the TAG will help you to explore issues related to the STD Program to build a list of programmatic questions for the research work to address. For this version of the TIR, it is assumed that the STD Program emphasizes delivery of effective and appropriate services for sex workers and their clients. Next, together with the social

scientist, you will then "translate" these programmatic questions and adapt the interview Guides included in this manual. The modified Guides can then be presented to the TAG for further refinement and input. The TAG also will make several other strategic decisions about the focus of the research, such as geographic scope and which language group(s) to work with. Once these decisions are made, research site(s) can be selected and a budget for the activity can be prepared.

The social scientist on the TAG will also serve as the "technical lead" for conducting the research and in this capacity will be responsible for selecting, training and supervising the field research assistants. She/he will implement the research from the stage of gaining

access to the field, establishing the research team in the field and beginning data collection. She/he is also responsible for the management of the data, including proper documentation after field work, supervising data entry, and assuring back-up of electronic documents. The technical lead also initiates and supervises data reduction and analysis.

Figure 1-2. Example of a Guide

GUIDE TWELVE Communication

Interviewer Instructions: In this interview you will ask for the informant's experience with communication about sexually transmitted illnesses. It is assumed that you will be asking these questions of "key informants" identified through previous interviews.

Question



Today I am interested in talking with you about the ways in which people learn about sexually transmitted illnesses. Would you mind talking with me about this?

1. Can you tell me some of the names of sexually transmitted illnesses with which you are familiar?
2. How did you learn about these illnesses (probe for different channels: people, media, print)?
3. What did you learn about them (probe for cause, transmission, treatment, prevention)?
4. Are sexually transmitted illnesses a subject of conversation among community members? If yes, why? If no, why not?
5. Are there any sexually transmitted illnesses which are not believed to be treatable by cos-

The social scientist also produces the final report, but the TAG will ideally review the findings and assess and summarize their implications. Each TAG member also will ideally write a "spin-off" based on the research. For example, the health communication expert should design an education/communication strategy based on the results of this research. This would lead to future activities which take the findings into consideration and hopefully result in more targeted and effective programs.

While each research site is different and some limitations may arise, the entire TIR process is designed to be completed within six months. This assumes approximately two months for preparation and activity start up, two months for data collection, and two months data analysis and completion of the final reports. Figure 2-1 gives an estimated timeline for TIR implementation, highlighting the important administrative steps involved in the process and the major phases of data collection.

F. Objective of this TIR Manual

The objective of the TIR Manual is to enable you to organize a technical advisory and social science research team for conducting research related to experience with sexually transmitted illnesses among people in the setting of commercial sex. The ultimate goal is to collect and synthesize information from an important group of users of STD services that will enable you to improve your STD program.

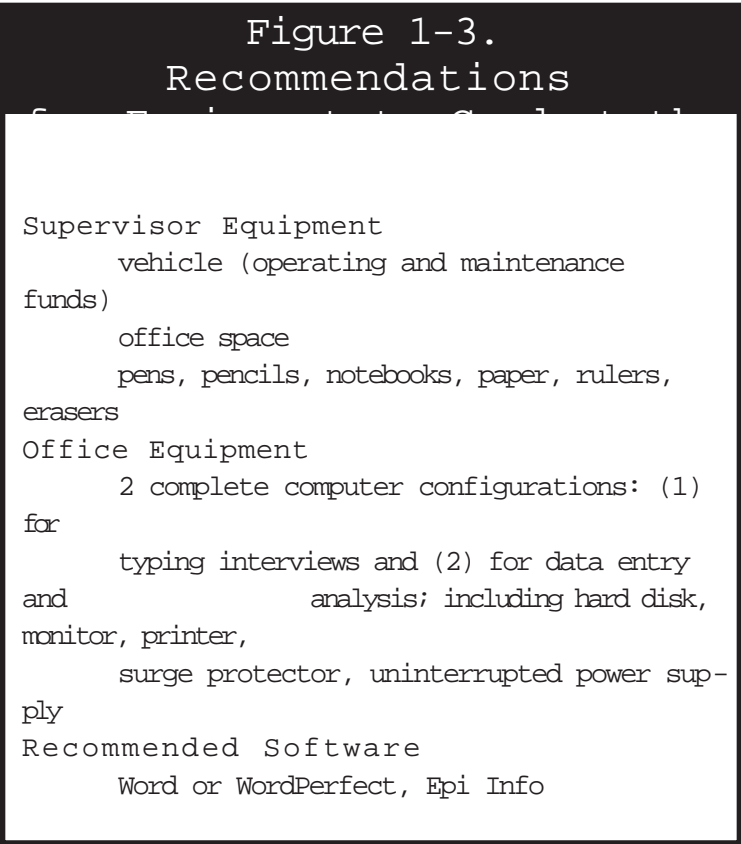
G. Using this Manual

This manual spells out steps for organizing and conducting field work, analyzing findings and using results in a logical order. Although we suggest that TAG members not receive copies of this manual until after the exercise to prepare programmatic questions is completed, the TAG members should be engaged at key points for every stage of the activity to ensure their participation in strategic decision-making.

H. Contents of this TIR Manual

This Manual is divided into three parts: the first part consists of eight Chapters; the second part contains two Appendices, including one that giving biomedical information on four common STD syndromes and others that provide additional information for users of the Manual; the third part consists of 13 data collection Guides (Guides 0 through 12). The Chapters provide background information and instructions on conducting the research, managing the data, analyzing the data, writing the report, and creating management tools for the STD Program. Appendix A will help orient those unfamiliar with STD history,

epidemiology, clinical manifestations, diagnosis, treatment and control measures. Appendix B contains a table of acronyms and reference information. The Guides are the instruments used in the field to collect the data. An example of a Guide is found in Figure 1-2.



I. Objectives of the Study

As indicated above, the objective of this version of the TIR is to document perspectives and behaviors related STDs and to use this information to improve the STD Program. STD clinic users as well as non-users may be interviewed. What is important is that a broad range of individuals broadly considered to be members of a high-risk population for STD are included in the activity. The results of this research will enable you to:

- understand the issues related to illness management, gender-related access to treatment, partner notification, and post-treatment behavior;
- train STD service providers to communicate more effectively with STD patients;
- design STD services to improve service delivery considerations such as cost, quality of care, and provider-client interaction;
- design or improve an outreach activity to deliver STD services, provide a community-based educational intervention, or offer a combination of both in the environment where commercial sex occurs;
- develop effective communication interventions to increase demand for STD services or improve key behaviors; and
- design or improve an existing STD prevention program.

J. Essentials for Targeted Intervention Research (TIR)

Figure 1-3 shows recommendations for equipment to conduct the TIR.

K. Distinguishing Between Provider and STD Clinic User Perspectives

Often, service providers and those who may use their services have very different perspectives (or conceptual models) about what it means to be ill. From the patient's perspective,

"being ill" usually means they cannot perform the functions of daily life. In contrast, service providers often define being ill as having an identifiable, measurable, named disease. One result of this different perspective is that the concerns of STD clinic users are sometimes ignored because medical people cannot find a name for their symptoms or complaint.

The TIR is designed to gather information which can help reveal this perspective. This perspective includes the ideas held by people who present for care at STD clinics or who are highly sexually exposed (commercial sex contacts) and experience STD illness episodes whether or not they use clinical services. We must recognize from the beginning that this perspective is often different and may even be in conflict with the perspective of service providers. Understanding both perspectives can help managers and clinic personnel improve many aspects of service delivery and communications programs. For this reason, a brief discussion of the provider perspective (disease) and the community perspective (illness) is included below.

Western-trained medical doctors or nurses have been trained to think of disease as something abnormal. In this way of thinking, symptoms are related to a basic physical process, and disease can be measured by using western biomedical techniques. Each disease has its own signs and symptoms, and the clinician's job is to recognize these diseases by matching it with the presentation of symptoms among other cues. Once this has happened, physical treatments are used to correct these abnormalities.

On the other hand, lay persons generally define being ill quite differently. We have seen how service providers define being ill in terms of a poorly functioning or damaged body. In contrast, the patient's perspective on being ill is part of a much wider set of ideas used to explain misfortune in general. It usually is important for people with STDs to understand how the illness originated, its significance, how it effects his/her relationship with other people, and the various steps he or she takes to remedy the situation.

A problem arises when these two perspectives come into conflict. For example, if a patient goes to a clinic with a symptoms that cannot be detected by western medical techniques, the provider may dismiss the symptoms

as not being real. Yet for the patient, the symptoms are clearly real and disregarding them can erode the patient's confidence in the health care system and discourage him/her from seeking care in the future. Thus, this broader patient perspective should be considered when we try to understand how people interpret and respond to their ill health.

Helman succinctly summarizes the different perceptions: "'illness' stands for what the patient feels when he goes to the doctor, and 'disease' for what he has on the way home from the doctor's office." It is with this understanding that you can best approach this research activity.

L. Clinical and

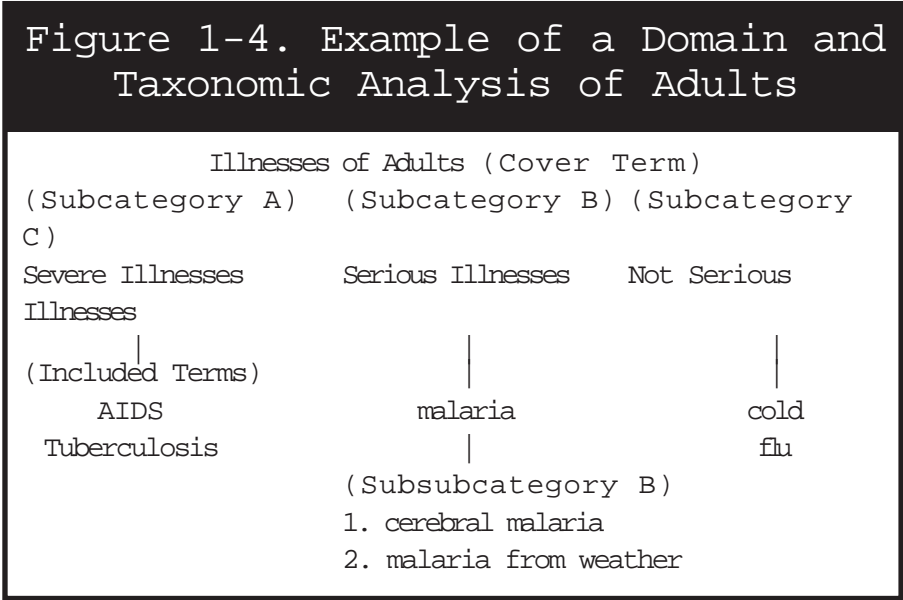
Illness Conceptions

1. Conceptual Domains and Taxonomic Analysis

A domain is a category of terms containing four elements: a cover term (illness of adults); two or more included terms (malaria, AIDS); a single semantic relationship (a kind of illness), and a boundary (there are illnesses which are not adult illnesses). Figure 1-4 shows you graphically how to conduct a domain and taxonomic analysis. This example from an East African country shows a domain of adult illnesses where the included terms are malaria and AIDS, TB, colds and flu. The semantic relationship is that

each included term is a kind of adult illness, and a boundary exists, since there are illnesses which are not adult illnesses.

A taxonomy is a set of categories also organized on the basis of a single semantic relationship. The Guides Two through Four



Epidemiological Features of STDs

Appendix A contains information on the clinical and epidemiological features of four common STD syndromes. The Appendix describes the history, epidemiology, and clinical manifestations, diagnosis, treatment, and measures of control. The four syndromes described are (1) urethral discharge/dysuria in men, (2) genital ulceration, (3) vaginal discharge, and (4) pelvic inflammatory disease.

M. Analytical Frameworks for Interpreting Informants'

ask for information about several categories of illnesses: illnesses of the nether area, sexually transmitted illnesses, and illnesses associated with specific symptoms. The taxonomy is "kinds of illnesses"—a term with greater breadth than a domain.

The TIR calls for both domain and taxonomic analyses. In Guides Two through Four, questions are posed to elicit information on several categories, or domains of illnesses. The question posed to derive this kind of information is: "Can you tell me the different illnesses that adults suffer from which affect the area of the body between the waist and the knees?" Domain analysis allows you to understand the terms included in several categories of illness; taxo-

nomie analysis allows you to understand the internal structure of those domains. This means that you will understand those subsets. For example, within the domain called illnesses of adults, you may find that there are those that are serious, those that are less serious, and those that are not at all serious. The subset in which an illness is placed may determine a great deal about the decision-making related to treatment and prevention. For more information on domain and taxonomic analysis, see Spradley (1979).

2. Informants' Explanatory Models of

STD-related Illnesses

The purpose of developing explanatory models of STD-related illnesses is to understand the study population's perceptions of illness etiology, timing and mode of onset of symptom, pathophysiological processes, natural history and severity, and appropriate treatments. Explanatory models are used by individuals to explain, organize, and manage illness episodes. They are developed by individuals in response to a particular episode of illness. They must be studied by examining the context in which they are used, which may include, for example, the social and economic organization and the dominant religious ideology of the community. Because a per-

N. Programmatic Questions for STD Control in the Commercial Sex Settings

Q

1. Structure and organization of commercial sex

1a. What are the different types of prostitution? Does both female and male prostitution exist? What are the economic relationships (e.g. SES of the client, level of economic dependence on other people like pimps or brothel owners, financial responsibility to family or others)? How do structural features, such as where the SW encounters/engages the client or where they go to have sex, affect their behavior and the likelihood to have risky sex or take preventive action? What are the strategies SWs use to keep safe?

1

1b. What are the different types of sex partners for SWs?

1c. How do SWs initiate as sex workers? How do they learn about "the business" of sex work? Is there a period when they do not self-identify as sex workers yet are at high risk?

1d. Do SWs have a history of risky sexual behavior before entering prostitution (e.g. partner change or serial monogamy)? What are some of the other characteristics of people who become SWs (e.g. history of sexual abuse, drug abuse, etc.)?

Q

1e. What are the characteristics of SWs that are most important to consider when deciding how to build a sample of SWs for the TIR activity?

2

2. Sexually Transmitted Illness Related Concepts and Practices

2a. What names do SWs and their clients give to illnesses, especially those transmitted sexually? How do they label symptoms? What words are used to identify symptoms of specific illnesses? Conversely, what illnesses are associated with specific symptoms? How are biomedical terms for illnesses understood and/or used by SWs and their clients?

Q

2c. Where do SWs and clients go for health care? What do SWs clients know about sexually transmitted illnesses-related treatment? Who can treat these illnesses (e.g. self, other SW, traditional or alternative health care providers, etc.)? Can the cosmopolitan health services treat them? Can the symptoms be treated? Can the illnesses be cured? How do SWs and clients know if the treatment has cured the illness?

2
contin-
ued

2d. What range of sexual practices exist among SWs and their clients that likely facilitate STD/HIV transmission (anal sex, use of drying agents, other sexual enhancements, lubricants, repeat use of the same condom)? Do they have sex during menses? Do they try and hide or disguise menses?

Q

2e. Do SWs or their clients see themselves at risk for STD/HIV?

3. Illness Management Questions

3a. How do SWs and their clients recognize signs and symptoms of sexually transmitted illnesses? What symptoms or signs are recognized first? Are these symptoms specific to sexually transmitted illnesses or are they symptoms which might be associated with a number of different illnesses? Are there specific sequelae which are identified with a particular illness? How are sexually transmitted illnesses distinguished from other illnesses? Are there signs and symptoms which are obvious to other people and affect sexual and therapy-seeking behavior?

3b. What symptoms prompt SWs and their clients to seek treatment? Are these symptoms specific to these illnesses or are they common to many illnesses?

3c. When and how do SWs and their clients decide to (or not to) seek treatment (including self-treatment)? What motivates SWs and their clients to seek treatment? What are the factors that prevent or delay treatment seeking?

3d. How does the network of individuals that SWs use for advice/information influence choices about seeking therapy? Does this differ by illness, degree of discomfort, experience as SW, type of SW (e.g. beginner versus experienced, brothel versus street-based, etc.)?

3e. How do SWs and their clients perceive different types of treatment? Is an injection perceived to be better, more powerful or more effective than pills, herbal remedies, home remedies, traditional or alternative remedies? Do SWs obtain treatment when they think they have an STD? Where do they go to get treatment? Why do they think it's important to get treatment? What treatment do they use (cosmopolitan drugs/antibiotics, herbal remedies, home remedies, etc.)?

3f. What do SWs and their clients do when they perceive themselves as having a sexually transmitted illnesses? Does their behavior change? Do they consult different people (e.g. other SWs, male or female friends, steady partners or spouse, clients, relatives, health providers, traditional healers, etc.) for advice than they might for other illnesses? What emotions are associated with these illnesses? Pride? Embarrassment?

3g. Do SWs and their clients abstain from sex during illness? Why or why not? Do

3

Q

4. Service Delivery Questions

4a. What are the types of health services SWs consider to be available for STD care?

4b. Is cost of biomedical services an impediment to use? ("Cost" includes the cost of transport, consultation, drugs and opportunity costs, such as time lost from work or child care.) What is the most important programmatic change(s) which would help overcome these barriers to seeking services/care?

4c. What are SWs and their clients' perceptions of the quality of care available, including provider attitudes, waiting time, privacy, supplies, waiting room atmosphere, clinic hours, and authority of service? Which of these factors are seen as most important by SWs?

4d. Is there a stigma attached to using the STD clinic or service? If yes, is this stigma an impediment to use? Is there a difference among male and female SWs attitudes?

4e. What changes would make it more acceptable or appealing to seek care/ treatment at any of the facilities available for STD care?

4f. What are the attitudes of providers about patients? Do they act as if these illnesses are like any other health problem? Are they judgmental? Do they maintain client confidentiality? What are providers' level of comfort with talking about sexual behavior and interacting with SWs?

4g. Do providers give behavior change and condom use advice in addition to curative information? Do they distribute condoms readily when they are available and/or suggest ways SW and clients can get condoms in the community?

4h. How can patient-provider communication be improved? What is the current interaction pattern? What is its impact on patient satisfaction? Is there a negotiated action plan for treatment, follow-up? What is the impact on compliance with prescribed treatments and medications?

Q

5

5. Partner Notification Questions

5a. What are the different types of partners SWs have (i.e., steady or regular clients, first time or one time clients; stable partners such as boyfriends, girlfriends and spouses)?

5b. Under what circumstances do SWs and their clients tell their partners about their sexually transmitted illnesses and how do they tell them? Which types of partners are informed?

5c. Do SWs and their clients refer any of their partners for treatment, and if so, which types of partners? Do they get their partners help in other ways?

5d. What skills do SWs and their clients need to improve partner notification? What existing communication skills could be built on?

Q

6. Post-treatment Questions

6a. Is it feasible for SWs and their clients to abstain from sex during treatment? Does this apply to all types of sexual behavior or all types of partners? Why or why not?

6

6b. Do SWs and their clients complete the treatment plan? Can they adopt and sustain other prevention advice (condom use, periodic abstinence)?

6c. How does the experience of having an STD change a SW or client's behavior after diagnosis and treatment? Do SWs return for follow-up when asked? Why, why not?

Q

7. Communication Questions

7a. Where do SWs and clients learn about what sexually transmitted illnesses, their prevention and treatment? What promotional efforts do SWs and their clients report having been exposed to?

7b. How important are sexually transmitted illnesses for SWs and their clients, relative to other considerations? Why or why not?

7c. Who do SWs and their clients trust for information about sexually transmitted illnesses? Do they go to different types of people for different kinds of information (sexuality, condom use skills, folk epidemiology)?

7d. What communication skills do SWs and their clients need to improve discussions (with client, partner, pimp, health care provider or peers) about sexually transmitted illness transmission, prevention, and partner notification?

7e. What provider communication skills are needed to improve SW and client satisfaction with services, negotiation of action plan for treatment, follow-up and compliance?

7f. What visual images would be acceptable to portray SWs and their clients suffering from sexually transmitted illnesses? What verbal messages could be used to discuss these illnesses without offending SWs or clients?

7g. Do SWs have problems interacting with people who represent government/institutions as outreach workers? What types of barriers are there to effective communication between them? Most importantly, what would improve the effectiveness of this communication?

Q

7h. How do structural features of commercial sex affect SWs communication strategies?

7i. What psychographic characteristics most likely to influence health seeking behavior related to STI can be used in communication messages or strategies?

8

8. Prevention Program Questions

8a. What are SWs and their clients currently doing to prevent getting or transmitting STDs (cosmopolitan, traditional and alternative means of prevention)?

Q

8c. What approaches might SWs use to improve the acceptability of condoms among their clients?

8
contin-
ued

8d. Given the different types of prophylaxis and periodic treatment programs that may exist, are SWs aware of them? Do they see them as a way of preventing STDs? How often do they get antibiotics and where do they get them? What other possible reasons do SWs decide to take antibiotics prophylactically to prevent STDs?

8e. What hygiene practices are used by SWs and clients to prevent STDs? What are the limitations that prevent SWs from adopting hygiene practices? Are they used the same with all types of clients?

8f. Do SWs screen clients for sexually transmitted illnesses? If so how? If not why not? What characteristics do they look for? What happens if a client appears dis-

Figure 1-5. Programmatic Considerations—Questions and

TOPIC	GUIDE(S) #
1. Structure and Organization of Commercial Sex	
What are the different types of sex workers and clients?	Guide 1
What are the most important characteristics of the setting of commercial sex to consider when deciding how to build a sample of SW for the TIR?	
2. Sexually Transmitted Illness Related Concepts and Practices	
How do people in the setting of commercial sex label illness, especially those transmitted sexually?	Guides 2-4, illness elicitation Guides
What do these people know about who gets sexually transmitted illnesses, when, and how to prevent and treat them?	Guide 5, Core Illnesses Guide
-etiology/epidemiology	Guide 10, Sexual Practices Guide
-transmission	
-long-term effects (e.g. infertility)	
What range of behaviors related to STD transmission and prevention to SWs have?	
-prevention activities (condoms, hygiene, etc.)	
-treatment activities	
3. Illness Management Questions	
<u>Identification:</u> how do people identify the first signs and symptoms of an sexually transmitted illnesses?	Guides 2-4, illness elicitation Guides
	Guide 5, Core Illness
	Guide 9, Clinic Questionnaire
<u>Recognition of Symptoms:</u> what symptoms prompt individuals to seek treatment? Are these symptoms	Guides 2-4, illness elicitation Guides
	Guide 5, Core Illness

Figure 1-5. Programmatic Considerations—Questions and Related Guides,

TOPIC	GUIDE(S) #
<p><u>Cues for action:</u> when and how do people decide to seek treatment/not seek treatment?</p> <p><u>Action:</u> What do people do?</p> <p><u>Sexual Activity:</u> Do people abstain from having sex during illness? If yes, when and why?</p> <p><u>Perception of Treatment:</u> How do community members perceive different types of treatment?</p>	<p>Guides 2-4, illness elicitation Guides Guide 5, Core Illness Guide 9, Clinic Questionnaire</p> <p>Guides 2-4, illness elicitation Guides Guide 5, Core Illness Guide 9, Clinic Questionnaire</p> <p>Guide 5, Core Illness</p> <p>Guides 2-4, illness elicitation Guides Guide 5, Core Illness Guide 9, Clinic Questionnaire</p>
4. Service Delivery	
<p><u>Cost issues:</u> Is cost of services an impediment?</p> <ul style="list-style-type: none"> -Transport -Consultation -Opportunity costs -Drugs <p><u>Quality of Care (perceived):</u></p> <ul style="list-style-type: none"> -Provider attitudes -Waiting time -Privacy -Adequate Supplies -Waiting room -Clinic hours -Authority of service <p><u>Stigma Issues:</u> Is there a stigma attached to using the STD clinic or service? Is this stigma an impediment to use? Is there a gender stigma to use?</p> <p><u>Barriers to Clinic Utilization:</u> Are there factors unrelated to STD clinic service configuration that constitute barriers for SWs and/or clients to present at STD services?</p> <p><u>Changes:</u> What changes would make it acceptable to go to the clinic?</p>	<p>Guide 11, Service Delivery Guide 9, Clinic Questionnaire</p> <p>Guide 11, Service Delivery Guide 9, Clinic Questionnaire</p> <p>Guide 11, Service Delivery Guide 9, Clinic Questionnaire</p> <p>Guide 11, Service Delivery Guide 9, Clinic Questionnaire</p> <p>Guide 11, Service Delivery Guide 7, Brothel Owners, etc.</p> <p>to Guide 11, Service Delivery Guide 9, Clinic Questionnaire</p>

Figure 1-5. Programmatic Considerations—Questions and Related Guides,

TOPIC	GUIDE(S) #
<u>Provider Communication:</u> What skills are needed to improve patient-provider communication?	Guide 12, Communication Guide 8, Health Worker Guide 9, Clinic Questionnaire
<u>Provider Attitudes:</u> What are the attitudes of providers about patients?	Guide 8, Health Worker
5. Partner Notification	
What are the different types of sex partners SWS have and how does that affect partner notification that they can do themselves? -terminology -communications skills -role of "gatekeepers"	Guides 2-4, illness elicitation Guides Guide 5, Core Illness Guide 10, Sexual Practices Guide 12, Communication Guide 7, Brothel Owners, etc.
Would/did the patient tell her/his partner about an sexually transmitted illnesses? Which partners are informed? Would the patient refer his/her partner for treatment? Help in other ways?	Guide 5, Core Illness Guide 10, Sexual Practices Guide 9, Clinic Questionnaire
What skills are needed to improve partner notification? What existing communication skills could be built on?	Guide 5, Core Illness Guide 12, Communication Guide 9, Clinic Questionnaire
What are the possibilities for clinic-based staff to assist with partner notification?	Guide 5, Core Illness Guide 11, Service Delivery Guide 9, Clinic Questionnaire
6. Post-treatment and Follow-up	
Do patients abstain from sex during treatment? If not, why?	Guide 5, Core Illness
Do the patients comply with (other) treatment/prevention regimens (condom use, drugs, herbs, etc.)? Do they comply with follow-up requests?	Guide 5, Core Illness Guide 11, Service Delivery
Do patients change their sexual behavior after diagnosis and treatment? If yes, how? If no, why?	Guide 5, Core Illness Guide 9, Clinic Questionnaire
7. Communication Questions	
<u>Channel Issues:</u> Where do people hear about sexually transmitted illnesses prevention and treatment?	Guide 5, Core Illness Guide 12, Communication
<u>Priority & perception of risk:</u> Are sexually transmitted illnesses a priority for community members?	Guide 5, Core Illness Guide 12, Communication

Figure 1-5. Programmatic Considerations—Questions and Related Guides,

TOPIC	GUIDE(S) #
<u>Authority:</u> Who do people trust for information about sexually transmitted illnesses?	Guide 5, Core Illness Guide 12, Communication
<u>Treatment:</u> What sexually transmitted illnesses are not perceived to be treatable by cosmopolitan services?	Guide 5, Core Illness Guide 12, Communication
<u>Patient Communication Skills:</u> What communication skills are needed to improve discussions about sexually transmitted illnesses?	Guide 5, Core Illness Guide 12, Communication
<u>Provider Communication Skills:</u> What communication skills are needed to improve patient outcomes?	Guide 11, Service Delivery Guide 12, Communication Guide 9, Clinic Questionnaire
<u>Message Content:</u> What visual images and verbal messages are acceptable?	Guide 12, Communication
8. Prevention Programs	
What are SWs and their clients currently doing to prevent getting/transmitting STDs?	Guides 2-4, illness elicitation Guides Guide 5, Core Illness Guide 6, SW Client Interview Guide 10, Sexual Practices
What is the current level of condom use? Attitudes towards condoms? (both SWs and clients)	Guide 5, Core Illness Guide 10, Sexual Practices Guide 6, SW Client interview
What are the range of current hygiene practices and how can they be addressed to be more effective for prevention?	Guide 10, Sexual Practices Guide 6, SW Client interview
How do different prophylaxis and treatment programs function, what is their acceptability for SW and clients, and how can they be more effective for prevention?	Guide 10, Sexual Practices Guide 6, SW Client interview
What prevention promotion activities are currently in place?	Guide 12, Communication
What partner notification issues could be addressed to enhance prevention programs?	Guide 5, Core Illness Guide 6, SW Client Interview Guide 10, Sexual Practices Guide 11, Service Delivery

A. Overview of the Process

You are about to form a team to collect information about sexually transmitted illness perceptions and experiences among individuals in the setting of commercial sex.. The process begins with you, the STD Program Manager, as the team leader and principal investigator of this effort. You will form a Technical Advisory Group (TAG) including, at a minimum, yourself, a local expert in communication/health education, a local expert in STD clinical services, an objective (non-national) health professional and a social

science researcher from a local university. The TAG will help guide the research and assure that its results are used to improve the STD Program. It is assumed that the members of the TAG work as advisors to the STD program. While each research site is different and some limitations may arise, the entire TIR process is designed to be completed within about six to nine months. This assumes approximately two months for preparation and activity start up, two to three months for data collection, and two to four months data analysis and completion of the final reports. Figure 2-1 is an estimated timeline for the TIR

Figure 2-1. Example of a Time Line for Implementation of the TIR

Steps	Time In Months									Personnel Required
	1	2	3	4	5	6	7	8	9	
1. Select TAG Team Members	X									All TAG Team Members
2. Define Local Programmatic Questions	X									All TAG Members
3. Make the Strategic Decisions about the Focus of the Research: Select Sites, Amend Guides to Match Local Priorities		X								All TAG Team Members
4. Develop Budget	X	X								STD Program Manager
5. Select and Train Field Researchers		X								Social Scientist and Field Researchers and Assistant
6. Gain Access to the Field		X								Social Scientist and Field Researchers

Figure 2-1.Example of a Time Line for Implementation of the TIR. Continued

Steps	Time In Months									Personnel Required
	1	2	3	4	5	6	7	8	9	
7. Conduct Guides One Through Four		X	X							Field Researchers Supervised by Social Scientist
8. Enter Data for Guides One Through Four			X							Field Assistants Supervised by Social Scientist
9. Analyze Data From Guides One Through Four and Make Adjustments to the Remaining Guides as Necessary			X	X						Social Scientist and Field
10. Conduct the Remaining Guides Supervised by					X	X				Field Researchers
11. Enter Data for Remaining Guides					X					Social Scientist Field Assistants Supervised by Social Scientist
12. Analyze Data From Remaining Guides						X	X			Social Scientist and Field
13. Reconvene TAG Team For Preliminary Discussion of Results and Brainstorming of Possible Spin Offs							X			All TAG Team Members
14. Start Final Report and Spin Offs							X			Social Scientist
15. Complete Final Report and Spin Offs								X		Social Scientist
16. TAG Team Meeting to Discuss									X	X All TAG Members

implementation, highlighting the important steps involved in the process and the major phases of data collection.

B. Identifying the Technical Lead

As STD Program Manager and principal investigator of the research, you are responsible for overall management of the TIR process. To successfully complete the TIR, your first and perhaps most important task will be to identify an experienced social scientist to assume the role of "technical lead" and supervise the research. The technical lead should be identified at the very start, even before calling the first TAG meeting. In this way, the technical lead will be a strong partner taking ownership of the research process and potentially help identify TAG members with complementary skills and experience.

Forming a close partnership with the technical lead is essential. At the same time it is important to clearly define the respective roles and responsibilities. The technical lead should report to you, the end user of the research results and overall manager of the TIR process. Her/his responsibilities, illustrated below in Figure 2-2, should be more distinctly related to aspects of the research process itself.

Referring to this list of responsibilities will be helpful in selecting a technical lead for the project and in describing your expectations. With

the combined skills and experience of an STD Program Manager and a technical lead, outside technical assistance should not be necessary. However, depending on availability of qualified social scientists in the country some technical assistance may be needed.

Figure 2-2. Responsibilities of the Technical Lead

- ◆ Provide technical expertise in qualitative research
- ◆ Adapt TIR protocol based on TAG recommendations
- ◆ Manage all stages of data collection, cleaning, analysis, and information dissemination:
 - prepare research workplan and budget
 - recruit interviewers
 - prepare and conduct interviewer training
 - monitor and supervise data collection in the field
 - recruit data entry and other administrative personnel
 - monitor and supervise data entry and cleaning
- ◆ Conduct data analysis
- ◆ Prepare written report

- ◆ Present findings and programmatic recommendations to the TAG to improve the STD program.

The first task, as noted in Chapter One, is to identify and invite individuals to serve on the TAG. While composition of the TAG is not fixed, the input of specialists in STD programming and clinical management, health communication, and social science research are essential for completing this work. It is also recommended that one individual who works in the health system but who is not a national be included in the TAG. A Chilean working in Uganda, for example, or a donor-funded project person, would fit this crite-

C. Setting Up an In-Country Technical Advisory Group (TAG)

As STD Program Manager, you oversee a large program with many components. In your position, you need to have the big picture, but you probably are not an expert in all of the individual components. By calling upon a group of experts to work with you, you benefit from their varied experiences. You can delegate some of the work involved. And you can make sure that you are building consensus so that the research results will be used

rion. This person can hopefully offer a more objective perspective on several issues to the group. We also suggest that one or more of TAG members have experience working directly with sex workers (SWs) in the country. As summarized in Figure 2-3, the TAG should ideally be composed of at least four individuals in addition to yourself, but may also include other specialists and/or community representatives as appropriate.

Figure 2-3. Possible TAG Members and Ideal Qualifications	
TAG Member	Qualifications
STD Program Manager	Experience in implementing STD prevention and control interventions,
	preferably also involved in the design
STD	and implementation of the national control program
Social Scientist/Technical	Experience in conducting qualitative
Lead	social scientific research particularly
	related to health and illness
Communications Specialist	Experience in designing and implementing
	health communications projects

Figure 2-4. Sample Agenda for the First TAG Meeting	
Welcome and Introduction	
Introduction to the TIR and Qualitative Research	
Overview of the STD Program and Context of TIR	
Clarification of the Rationale for and Role of the TAG	
Workshop: Generate List of Programmatic Priorities	
Discuss Agenda and Date for Second TAG Meeting	

Figure 2-5. Responsibilities of TAG Members	
<ul style="list-style-type: none"> ◆ Meet at key points during the TIR process (3 to 6 meetings) ◆ Participate as an interdisciplinary advisory team ◆ Recommend adjustments to the TIR protocol based on area of expertise and experience ◆ Help prioritize data collection ◆ Review and discuss preliminary findings ◆ Assist the technical lead in developing programmatic recommendations based on the findings ◆ ----- 	

As a way of integrating target group perspectives into the process of modifying the TIR, it may be appropriate for the TAG to include or consult with representatives from community-based interventions (such as peer health educators) in different research sites.

D. Deciding on Country Priorities for the STD Program

Persons selected to participate on the TAG should then be invited to an introductory meeting (see Figure 2-4 below for a sample agenda) where you will describe the current STD program, the purpose of this research, and the role of the TAG in the TIR process (see Figure 2-5 below).

An important task for this introductory meeting is to use the Nominal Group Technique (see Chapter Three, Section B) to list out and prioritize the programmatic needs and questions that should be addressed by the TIR. A TAG member in charge of clinical services, for example, might be interested providing care to more clandestine groups of SWs. Information about ways to encourage these SWs to come to a clinic can form the basis of such a strategy. Alternatively, a TAG member may express interest in improving patient-provider communication. In this respect, familiarizing providers with the popular terms used to refer to STD-related illnesses and symptoms would be useful. As STD Program Manager, you also may be interested in expanding services and face difficult choices about whether to establishing a separate STD care facility or incorporating STD services within a more comprehensive program. To make an informed decision, issues such as stigma, access, cost and acceptability of services for different types of patients can be useful to understand.

With the technical lead's assistance, you can then compare the list generated by the TAG with the list of programmatic considerations described in Chapter One and prepare a final list that reflects priorities and suggestions of the TAG. Each TAG member should be given the final list of priority programmatic questions and a copy of this Manual for their review and prepara-

tion for the second TAG meeting.

The focus of the second TAG meeting is to finalize the TIR protocol, including determining the research sites, deciding which Guides will be used, reviewing the Guides to decide what kinds of modifications are needed, and establishing field procedures. The Table of programmatic questions and related Guides in Chapter One may be useful when making these decisions.

E. Preparing the Research Guides

1. Adjusting the Guides to Local Priorities

This manual should be used as a guide for designing and conducting focused ethnographic research on STD-related illnesses in the setting of commercial sex. A primary responsibility of the TAG and especially of the technical lead is to adapt the process and the data collection Guides to match the programmatic questions identified by the TAG and reflect the local circumstances where they are used. To this end, specific questions will probably need to be added, modified, or eliminated from the guides to reflect these particular needs and circumstances. The TAG might decide, for example, to develop a health care provider guide that could be used with non-bio-medical health providers who treat STDs, such as traditional healers or drug sellers in the informal sector.

2. Review of the Guides

Guide One is designed to gather basic background information on how the commercial sex system functions in a particular site. It is assumed that Guide One is administered early in the TIR process and its results are used to adjust the remaining Guides or to help interviewers gain access to the field.

Guides Two through Four will yield lists of information, providing great breadth but little depth. The information from these lists is used to document a set of terms and gain an understanding of illnesses which informants think are sexually transmitted or which informants associate with specific symptoms known to be STD-related. The information derived from using this

series of Guides will then be used to create a list of core illnesses. These core illnesses will be investigated in more detail using the Core Illness Guide 5. Therefore, when making modifications, the technical lead will need to be certain that revisions are made to all the various Guides in the series.

For the Guides designed to get information on service delivery and communication, adding one or two questions may help customize them to the local situation. There are also Guides designed to obtain information from clients of SWs and decisions about how to approach these people will need to be tailored to the characteristics of the site. Also, there are several different instruments available for interviewing clients and the technical lead will need to decide which are most useful and practical based on the features of the research site.

We acknowledge that topics were omitted from the Guides in an effort to keep the research focused on STD-related illness conceptions and treatment behaviors among particular populations of SWs and clients. For example, questions on sexual behavior are in general not included, although there are a few related questions in the Core Illness Guide. If the research team is interested in gathering these other types of information, instead of altering these Guides we suggest you consider using other instruments designed specifically to gather this type of information. Caldwell, for example, has designed research instruments to collect information on sexual networking, Scrimshaw a Rapid Ethnographic Assessment tool on AIDS, and AMREF has undertaken a study on truck drivers. For more information, see the Reference Section in Appendix B.

3. Translating and Pre-testing the Guides

We suggest that draft translations of the Guides be prepared early in the activity before interviewers are trained. Care should be taken to ensure that the translated questions express the meaning and intent of the original questions. It is equally important that sensitive terms and phrases are expressed in appropriate, non-offensive ways. To test for both linguistic accuracy as well as conceptual comprehension, all of the questions should be pre-tested with target informants and, ideally, back translated into the orig-

inal language. Pre-testing the Guides may be done either prior to training interviewers, as part of their training, or early in the actual research phase. Questions that do not work well at particular field sites should be modified as appropriate by the local field team.

F. Selecting the Research Site(s)

1. Sampling Considerations

This research activity is designed to be focused and efficient. You cannot, and would not want to, interview all SWs and clients in the country about STDs. You must decide, therefore, who to include and who to exclude from your sample. Some difficult decisions will be required prior to field work so that the data collection can be targeted and within reasonable limits. These decisions will pave the way for effective supervision and data analysis.

Decision-making about sampling falls into the following five categories:

- ◆ program scope
- ◆ language groups
- ◆ SW/client community types
- ◆ geographic diversity
- ◆ sample size

Since you cannot use the Guides in a number of settings at once, you must begin by selecting one site to work with. The sampling decisions mean choosing among sites and people.

a. program scope

The first consideration is the scope of the program. If this research is being conducted for a national program, work through the points below from the national perspective. If you are working at smaller level, the collection of data will be restricted to the catchment area of the program. For example, if your program is limited to a region or a district, you will conduct your research within that area. Nevertheless, if there is significant cultural diversity within your program area, you will still need to consider further reducing the scope of the data collection, and you should work through the points below as much as is applicable.

b. language groups

It is recommended that one language group is selected as a first step. This may be the national language, the language of the people with the highest incidence of STDs, or a language group in a particular region of the country where program efforts can be focused.

c. community types

Once a language group has been selected, you may want to select either an urban, peri-urban, or rural focus depending on program priorities you have already identified early in the TAG process.

In the first stage of data collection using Guide One, you will collect information about the range of different types of SWs. These different types of SWs may be thought of as communities; researchers with anthropological training may think of this as a typology of different kinds of commercial sex. Each community of SWs and clients will probably have different characteristics. These characteristics may have an effect on the numbers of clients SWs have, the probability that their clients use condoms, or what they or their clients do when they think they have an STD. Clandestine prostitution, for example, may exist in an area of the city where the factories are located or there may be commercial sex activity in small towns along a major highways that serve as trucking

routes.

In general, the combination of higher frequency of client contacts, lower condom use and lower use of health services for STD care is found in low socio-economic neighborhoods of urban areas and along commercial trade routes (seaports, truck

routes, etc.). If extending STD service delivery to clandestine SWs and their clients is an identified program priority, discovering the characteristics of this community and developing a sampling strategy that include this sub-group will be important. You will also need to consider the location of STD services that already exist and the geographic range or catchment area for the clinic as compared to how easy or difficult it is for SWs or clients to travel to potential clinic sites.

d. geographic diversity

Logistics dictate a limited geographic scope. The supervisor will need to be in almost daily contact

with both the field sites and the clinic sites. The more locations selected, and the greater distance between sites, the more stress on the supervisory capacity, higher cost for transport, and greater complexity for analysis.

The technical lead will need to establish reliable communications links between the project office where the secretaries and other adminis-

Figure 2-6. Recommended Sample Sizes for One Research

GUIDE	SAMPLE SIZE
Guide 1	5 interviews
Guide 2 - 4	5 interviews per interviewer per guide (20 interviews per interviewer)*
Guide 5	5 interviews per illness *
Guide 6	5 interviews per interviewer * **
Guide 7	5 interviews per interviewer **
Guide 8	5 interviews **
Guide 9	2 interviews per interviewer
Guide 10	100 males 100 females
Guide 11 (A&B)	2 interviews per interviewer per section
Guide 11 (C)50	males
Guide 12	2 interviews per interviewer
* Repeat interviews with same informant are permissible.	
** Guide can be adapted to use focus group method.	

Figure 2-7. Potential Personnel

- ◆ field supervisors
- ◆ interviewers
- ◆ data entry staff
- ◆ secretarial/logistics staff
- ◆ data analyst

trative personnel are located, the field sites and the clinic(s). For every different community selected, two interviewers will be required. Efforts to match the sex of the interviewer to the sex of the respondent are usually taken for this type of research (i.e. one male and one female interviewer). However, we acknowledge that in many settings any interviewer with excellent interviewing skills can overcome the gender barrier to successfully interview respondents of the opposite sex. Housing for the interviewers will be required for each site.

Typically, there may only be one or two STD clinics in an entire region. For this reason, you may find it difficult to study rural populations near these clinics. However, the ideal field population would be two to four communities and the nearest STD clinic.

e. sample sizes

Figure 2-6 gives suggested sample sizes for each interviewer using each data collection Guide. To calculate the number of interviews per site, these numbers should be multiplied by the number of interviewers working in that site. For the series including Guides Two to Four, the same informant can be repeatedly interviewed to give information. For Guide Five and Six, a group of informants which are more comfortable giving accurate and expanded responses hopefully have been identified. It is not required to return to these same informants for Guides Five and Six, however if this is possible it has the benefit of enabling interviewers to probe more deeply for information about the respon-

dent's personal experience. For other Guides used with SW informants (Guides Eight and Twelve) it is less important to return to the same informants since the information to be collected is not as personal as for Guides Five and Eleven. The remaining guides are applied either to different types of informants (clients or brothel owners, pimps, madames, etc) or are administered in the STD clinic setting thus sampling should be done so as to maximize the diversity of the sample.

Figure 2-8. Characteristics of Field Interviewers Who Work in

- ◆ Empathetic and non-judgmental attitude towards SWs and clients.
- ◆ Has experience with, knowledge of and ideally access to both establishment and street-based prostitution.
- ◆ Has experience interviewing individuals with depression, anger or other psychological problems.
- ◆ Has strong ethnographic interviewing skills and experience conducting interviews.
- ◆ Has good listening and writing skills.
- ◆ Has an ability to detect, interpret and respond appropriately to situations when the personal safety of the interview team may be at risk (potential violence, crime, etc.).

2. Field Sites and Personnel

The number of research sites and their characteristics will vary in each situation when the TIR is applied. As mentioned earlier, it is the TAG's responsibility to set inclusion and exclusion criteria guiding the selection of research sites. Certainly, the prevalence of commercial sex and the community's access to biomedical clinics for STD care are important considerations for site selection. Figure 2-7 illustrates possible personnel needs for field

research, but staffing decisions (e.g., number and gender of interviewers, field-based or centrally-based support staff, specific staff functions) should be made by the technical lead based on the her/his professional judgment and understanding of unique country conditions.

G. Budgeting

The budget for the TIR will depend on what resources, both monetary and human, are available. The budget also will need to match the scale and scope of the research, for example its

geographic scope and the selection of guides to be used. The budget will also need to accommodate the time available for data collection and analysis, for example will staff be dedicated full-time to the activity or will more part-time staff be required. Some typical budgetary considerations include salaries, per diem and travel, supplies and equipment, and communication costs. The specific budget categories and amounts will need to be determined by the technical lead according to local circumstances.

H. Selecting Ethnographic Research Assistants (Interviewers)

Choosing effective interviewers is critical to the success of the TIR. Identifying interviewers who can work effectively in the setting of commercial sex is probably the single most important

aspect of interviewer recruitment. Identifying interviewers is not easy and some creative approaches may be necessary, including considering alternative sources of qualified persons that may be available in your community such as various types of students or professional groups like journalists.

As gender may influence the interviewer-informant interaction, achieving a gender balance may be an important consideration when hiring interviewers. There is, however, no broad consensus as to whether interviewers and respondents should be of the same gender. In some settings and for some populations matching interviewers and informants on gender is important, while in other places it is less so and interviewers of the opposite sex can easily overcome any barriers with good interviewing techniques. The technical lead will need to decide early on about gender representation among interviewers so that she/he may recruit accordingly. One practical approach would be to recruit

Figure 2-9. Suggested Training Topics and Participatory

TOPIC	PARTICIPATORY TRAINING APPROACH
Purpose of the research	Exchange prior experience with field research
Introduction to STDs and STD epidemiology symptoms,	Game to explore common misconceptions about STDs,
	and risk behavior
Individual exercise	Read and summarize an article on STDs or the TIR approach
Interviewing techniques	Develop a short interview guide and practice interviewing a
fellow	trainee (working in pairs) while exploring a
non-sensitive topic	
Note taking	Practice interview with note taking followed by a discussion
	of problems encountered
Issues related to interviewing	Discussion of informed consent and confidentiality
Identifying informants	Small group session to brainstorm about how to identify and
	approach informants
Review translated guides	Small group sessions to review language and wording to
familiarize	interviewers with the guides and to address possible prob-
lems	
Practice interviewing using actual guides	Interviews and note taking in the community with observation
	and feedback from the trainer and follow-up discussion of
	problems and issues encountered during administration
Group exercise	Conduct a small scale community mapping exercise
Specific trainee needs	Open discussion among trainees to exchange practical expe-
riences	

get additional feedback from trainers, and express specific

both female and male interviewers and use them flexibly at the beginning of the research to assess if gender matching is important for some types of informants.

An attempt has been made to make the TIR quite structured, specifying a process for field work, offering ready-to-use Guides and giving some analysis instructions. However, the most important single factor in determining the depth and quality of the information will be the interviewers skills when conducting and documenting an interview. Most crucial is the ability of the interviewers to probe, to ask follow-up questions, and to attempt to get further answers rather than just accept the first one offered. This is especially important because the tendency of many respondents will be to give one short answer to "satisfy" the interviewer. The technical lead will be responsible for training research assistants in the techniques of qualitative data collection.

The technical lead of the TIR must be an experienced social science researcher with highly developed skills in systematic and in-depth interviewing. He or she must have experience in how to access the field sites, how to establish a field site, and must anticipate the requirements and pitfalls of field work. The technical lead also must be given enough resources and authority to carry out the work from beginning to end in an efficient manner. This person should run the training of the interviewers and establish him/herself as the manager of technical and administrative aspects of the activity. In this Manual, we assume that the technical lead is part of the TAG and therefore will have access to medical facilities, will have assistance with interpretation of the data, and will collaborate in an interdisciplinary team so that the results are used to improve the STD program.

The technical lead of the TIR will need to select interviewers for this activity while keeping in mind several desirable characteristics summarized in the figure below. We should recognize that it is unusual to find one person who naturally possesses all of the characteristics listed here. A more practical strategy will be to build a team of individuals that together as a group have as many of these characteristics as possible. For example, someone who has direct access to sex work establishments may be a member of the health care team who is sen-

sitive to the needs of SWs. Alternatively, there may be an interviewer who has never worked with SWs but s/he is very experienced in the techniques of ethnographic interviewing and there is reason to believe that s/he will be an effective interviewer. The technical lead may consider hiring members of the target community as interviewers, but target group membership should not be emphasized over the interviewer characteristics and skills outlined in Figure 2-8.

I. Training Interviewers

The content and length of the interviewer training will depend on the skills and prior experience of the interviewers selected. It is important that training sessions be as specific as possible to the actual work that the interviewers are expected to carry out. Therefore, it is useful to develop a workplan as one way to make careful preparation for data collection and share this with interviewers during the training.

As mentioned above, it is ideal to use interviewers with previous experience with in-depth interviewing, but this is not always possible and the training approach will have to be developed accordingly. Training sessions can be designed to last 3-5 days and to cover a range of topics. At the end of the training, the interviewers should at a minimum have gained the following types of knowledge and skills:

- ◆ Understand the purpose and goals of the TIR
- ◆ Have a basic introduction to STDs and STD epidemiology
- ◆ Understand how and why to gain informed consent
- ◆ Improve their ability to approach and interview informants
- ◆ Improve their note taking techniques

To ensure the most effective training possible, participatory techniques that directly engage trainees in the learning process should be emphasized whenever possible. Interactive small group learning and actual practice in interviewing and note taking will be important for to evaluate the training process and accommodate individual trainee needs. Depending on the amount of relevant field experience the interviews already have and whether or not the TIR

supervisor thinks it is appropriate, practice interviews can be conducted in an STD clinic waiting area or with people in the community that are accessible through a community-based NGO. For example, it may be practical to interview people attending a previously scheduled counseling/education session. Trainees should be encouraged to express their concerns about working with SWs and their clients and to try and anticipate challenges with field work. We recommend that if at any time interviewers express discomfort or negative views about people working in the setting of commercial sex, they should no longer be included in the interview team. Suggested training topics and participatory techniques are presented in Figure 2.9.

J. Gaining Access to the Field Sites

1. Communities

The challenge of this phase in the research activity should not be underestimated. This can be surprisingly challenging both in terms of the time or the measures needed to gain permission and acceptance by key representatives in the community. Entering a community to talk to anyone about sexual behavior is a challenge, and entering the setting of commercial sex to talk to SWs, clients or gatekeepers like bar or brothel owners, pimps and madames is equally challenging. The particular challenge of collecting information in this environment must be carefully considered since the consequences of not managing field work adequately can put interviewers at considerable personal risk. Safety measures in particular should be carefully planned. In some situations, an effective strategy can be to adjust the time of day for interviewing to minimize security concerns.

Several weeks before the training, the TAG should select a field site together with the administrative officials of the area. TAG members can then ask appropriate community leaders' permission to bring several interviewers to the site. Some community leaders can be especially helpful facilitating access to the establishments and streets where commercial sex occurs. These officials also will ideally help explain the research activity to police officials so that, the

interview team can refer to this official who is aware of their work should problems arise in the field.

After gaining permission to conduct the research, appropriate housing and transportation arrangements should be made. Even though the length of the fieldwork will be short, this is not as easy as it appears. It will often be the case that a community leader will offer to house the interviewers in her/his accommodations. Even though this is a generous gesture, efforts should be made to avoid this situation. It is not appropriate for the interviewers to be living with anyone who might be seen as influential in the community. This can undermine the interviewers need to establish an impartial reputation with respondents. Furthermore, this type of arrangement can lead to violations of interviewer-informant confidentiality.

Sometimes field work will occur in the setting of commercial sex and must be conducted in the evening or at night. This means that the field interview team will finish their interviews late in the evening and need to meet in a safe and comfortable place to have an opportunity to share their experience and to complete their fair notes. It is therefore advisable for the team to have access to a common meeting place such as the place where they are staying if appropriate or the lobby of a hotel or office that can be used at night.

While on the way to the field site(s) for the first time, the new interviewers should visit the important administrative officials to introduce themselves and inform him/her of the arrangements to work with community leaders and gain access to informants. Upon arrival at the field site(s), the interviewers should be settled into their accommodations and introductory visits should be paid to the community leaders. After these introductions, community leaders collaboration with the research team will be authorized and data collection can officially begin.

2. Clinic

The same procedure should be followed for the clinic site. The administrator of the clinic should be approached to request permission to conduct the research. A copy of the Guides should be given to the administrator and the research process should be described. At this

point the administrator or clinic manager may request some adjustments to the clinic interview procedure. An effort should be made to accommodate as many of these requests as possible and to conduct the research in a manner that is least disruptive for clinic procedures.

The process for administration of the Clinic Guide also should be explained to all providers who might take part in the research activity. They should be encouraged to participate in the research. At the end of the activity, results ideally will be shared with them so that their services might benefit and better meet the needs of their patients.

3. Commercial Sex Establishments

Preparation for conducting interviews in the setting of commercial sex also requires permission by the establishment owner/manager or in some cases, a pimp. Similar to the clinic setting, the schedule and logistics for data collection should be considerate of the concerns of the establishment. It is important to always be sensitivity to the impact interviews can have on "the business". For example, the researchers may want to go to a bar on a busy night such as Friday or Saturday to be able to conduct many interviews at one time. However, if a SW is occupied in an interview while potential customers are waiting, the manager of the establishment will probably see the research activity as disruptive. One possible solution is to go to the establishment on a Friday or Saturday night earlier in the evening while the SWs are arriving and there are still few clients there.

4. Street-based Commercial Sex

In circumstances where a pimp involved in street-based commercial sex, the approach to field work will be similar to that for establishment-based sex work. If, on the other hand, the SW is working the streets alone, an effective strategy may be to approach her/him directly and offering to conduct the interview in a safe place. For example, some researchers have relied on a well lit public facility with adequate seating and privacy and others have used a vehicle. Scheduling field work in this setting could also be planned at a time before clients arrive in great numbers and before safety becomes a problem.

5. Preparing for potentially dangerous

situations in the field

Before going into the field sites, the technical lead will need to prepare the field interviewer team to be able to detect and respond to potentially dangerous situations that can arise in the setting of commercial sex. Problems can occur with respondents who are under the influence of drugs or alcohol. Problems can occur when it appears that a respondent may have a mental illness. And problems can occur when a situation quickly becomes dangerous such as with street crimes crime and police raids. The members of the field interview team should discuss and agree on a way to assess these situations while they are happening and agree on a way to communicate with each other to make quick decisions. The technical lead should carefully consider these types of problems and give clear guidance on what action(s) to take if they arise.

K. Selection of Informants

This version of the TIR is designed to explore the unique aspects of the setting of commercial sex and the various people operating in this setting (SWs, their clients and gatekeepers like pimps, madames, brothel owners, etc.). The focus of the sampling strategy should be to represent a broad range of different types of commercial sex settings.

Before developing this sampling strategy, the technical lead will need to conduct a series of interviews with persons who are knowledgeable about the different forms of commercial sex that operate in the study site(s). It was with this need in mind that Guide One was developed. For example, it may be a priority to target street-based female or transvestite male sex workers or there may be other forms of clandestine commercial sex that are important to consider.

A sampling strategy can be refined through this process of interviews with persons knowledgeable about the commercial sex system coupled with the process of defining programmatic questions during the first TAG meeting. STD-related illness perceptions and treatment experiences should be elicited from a range of individuals associated with commercial sex, reflecting a wide variety of occupations, lifestyles, groups and risk behaviors present in the setting of commercial sex. We suggest that an important group to include will be those settings where SWs have relatively high numbers of partners in a given time period (e.g., number of customers in the last 24 hours or in the last week). It also is important to consider SWs who tend not to go to STD services or who have poor access to condoms and limited ability to require their sex partners to use them. Frequently, these factors are associated with SWs at lower socio-economic levels who have many clients per night. Of course, the clinic portion of the TIR intentionally selects individuals who are currently experiencing symptoms of STD infection.

Two general types of informants for the TIR can be described: those individuals who are encountered only once in the study and "key informants" who are interviewed in depth and more than once during the study. Key informants are individuals who appear to have particular knowledge and experience with STD-related ill-

nesses and symptoms and who are able to talk quite freely about it with interviewers. Interviewers should be encouraged to complete several interviews before identifying a few individuals who are particularly informative. Key informants may be a more experienced SW, a young SW who just started working, SWs or clients at a seaport or truck stop, or the madame of an establishment. There are no rigid requirements or restrictions for choosing key informants.

Clearly, individuals who have experience with a sexually transmitted illness may be a valuable informant. However, personal experience with these illnesses is not the only characteristic of interest and is not a requirement, particularly for clients of SW and for brothel owners, administrators or pimps. It is also important to collect information from those who act as "gate-keepers", in other words those who control information about STD or control access to resources such as STD care or condoms.

The decision of whether study participants should be compensated in some way for their time should be made in the field. When making this decision, it is important to consider that payments may change the relationship between informants and researchers. This change can affect the motivation of informants to agree to be interviewed thereby affecting the validity of the data. However, it is important to recognize that informants are giving their time, for which some form of compensation may be appropriate. It may be decided that informants should be reimbursed for expenses related to their participation in the research, such as transportation. Many researchers favor the use of non-monetary compensation and find creative solutions to this problem such as offering refreshments, a favorite snack, or a supply of condoms or lubricant.

L. Confidentiality and Informed Consent

The researcher has the responsibility to protect participants' privacy and preserve the confidentiality of the information they provide. As researchers we are being given information that is extremely sensitive and private. In the collec-

tion and storage of data, steps should be taken to make certain that only authorized people have access to the information and that interviewees are identified only with code names, initials, or ID numbers to protect their identity. The study participants must feel confident that the information they provide is kept confidential. If they do not trust the confidentiality of the interview, they may hesitate to give reliable information. In many situations, the people involved in the setting of commercial sex have strong feelings of suspicion towards institutions and individuals they see as threatening. It is therefore critical that the field interview team build a relationship with SWs and "gate-keepers" so that there is a basic sense of trust between them.

Trust is a key aspect of field work with this study population. It is not only built on assurances of confidentiality but also on the personal commitment of interviewers to understand the point of view of informants and offer concrete assistance to the respondents. Ideally the degree of personal commitment of the field interview team is either based on the reputation of a community-based organization that has worked with SWs or it is based on direct personal experience respondents have had with an organization or individuals associated with the TIR activity. The kind of assistance that is valued by this study population should be discussed among research team members. The kinds of assistance offered in other similar types of activities have included the following:

- ◆ Free condoms and/or lubricant
- ◆ Free education materials
- ◆ A willingness to answer health-related questions
- ◆ Information about social and medical resources available in the community

Other ways the field interview team can "give something back" to the respondents could be to offer: access to free STD services by special arrangement so that they have a shorter waiting time, access to free STD drugs, or access to free group counseling/education sessions through a community-based NGO.

Before any interview is conducted, it is important to obtain permission from each individual who participates. This permission is called "informed

consent". Consent often is obtained by reading a statement about the research to the informant and asking for their signature indicating their agreement to participate. In populations with low literacy, requiring participants to sign a formal document may actually hinder the progress of the research, in which case verbal consent is sufficient. The important point is that the interview process is explained to each participant and then he/she is given an opportunity to refuse participation or stop the interview at any time.

If there is a local Human Subjects Committee, you will need to get official permission from the Committee to conduct the research. This committee will review the procedures in place to obtain informed consent, preserve privacy and protect confidentiality. Whether or not a review of this type is necessary, the interviewers should always administer Guide Zero or a modified version which describes the nature of the research, the way the results will be used, the risk to the participant, and the benefits. The statement should not contain any unrealistic promises about the purposes or results of the study. The statement should include the name, address and phone number (if appropriate) of the person conducting the research so that any participant may follow up with additional questions. Finally, and most importantly, the statement should explain how the information given will be kept confidential.

M. Taking Notes

Interviews should be recorded at the time of the interview into Field Notebooks. The notebooks should be sturdy enough to withstand the rigors of field work. Each interviewer should be issued two books at the start of training. One book will be called "Field Notes #1", and the other "Fair Notes #1."

1. Field Notes

Field Notes are what interviewers write during actual interviews in their Field Notebooks. The Field Notebook contains notes taken on the spot and should include the question being asked as well as the response. Other information will include the name and age of the respondent, the date and time of the interview, the location, and

A. Introduction

In this section describes the various methods used for TIR field work. A complete description of each method is beyond the scope of this Manual. To get a more detailed description, the user is encouraged to consult the references listed in Appendix B.

The seven research or analytic tools described here include:

- ◆ Nominal Group Technique, used by the TAG to establish local programmatic priorities;
- ◆ Semi-structured interviewing is the basic research method used to administer most of the Guides and serves as the "umbrella" method under which other research tools are used;
- ◆ Free-listing, used when administering Guides One through Four;
- ◆ Taxonomic analysis, is applied after data is collected to understand the internal structure of domains and then develop scales;
- ◆ Scales, are a way of categorizing information given by informants;
- ◆ Case history, is used in the Core Illness Guide and the Clinic Guide to document signs, symptoms, decision-making, and actions for a specific illness episode; the case history method is used to analyze the data from the Core Illness Guide and the Clinic Guide to understand the decision-making patterns for particular types of illnesses; and
- ◆ Explanatory models, are holistic ways of examining the process by which an illness is patterned, interpreted and treated.

B. Nominal Group Technique

The Nominal Group Technique is generally used to encourage a group of people to come to a consensus about issues. The benefit of this technique is that it moves between individual and group decision-making, allowing each participant to voice their opinion before the group dis-

cussion begins. In this Manual, the Nominal Group Technique is recommended as a method for TAG members to build consensus about local programmatic priorities about the STD Program.

To begin, each TAG member writes down a list of programmatic issues they believe are priorities for the STD Program. You should encourage them to think not only of their own program are but also of other areas which may be outside their area of expertise. The technical lead or facilitator can participate in this activity but give answers after all others have finished commenting in order not to influence the discussion.

Second, ask each TAG member to read his/her list to the group. The facilitator writes down each issue on a blackboard or flip chart. At this point, there should be no discussion about the merits of each item on the list. If an item is unclear, participants should have the opportunity to further explain the issue they have raised so that all participants have a similar understanding of why the issue was listed.

Third, ask each TAG member to copy the larger list onto their own piece of paper and have them rank the items on the list, from 1 (being the most important) to n.

Fourth, ask each TAG member to read off the rank of the items he/she has developed, and write down the numbers beside each issue for all to see. Figure 3-1 is an example of what this might look like.

Fifth, review the ranking to see if there is any consensus about any of the issues. Use another color to write down the final ranking if there is agreement from all participants. For example, the ranking in Figure 3-1 yielded the same rank for the issue concerning separate STD services so this ranking emerged by consensus.

Sixth, for each issue where the rankings differ, discuss the issues and allow time for different perspectives to be aired. Encourage the group to come to a consensus about the ranking for each issue. Write the final ranking for each issue separately using a new color or a clean piece of paper. This final ranking list will become the "local programmatic issues" referred to in

this Manual. The list will be used to adjust the TIR field work to collect information that is relevant for program design. We suggest that only after completing this exercise, do TAG members have an opportunity to compare this list with the general list of programmatic questions given in Chapter One, Section N.

This technique also may be used for a TAG meeting after the research findings have been presented. This is useful if TAG members' views of the priority of particular programming issues have changed based on the results of the research.

C. Semi-

viewers have more flexibility to adjust the interview for each respondent. It is important to standardize the questions so that responses from different respondents can be compared. Thus, specific standardized initial questions are prepared. After each initial question, interviewers use a set of skills including probing and following leads to elicit more in-depth information. Probing and following leads will allow the interviewer to get more in-depth responses to the initial question. This type of follow up technique is the advantage semi-structured interviewing has over more structured interview formats.

In general, there are three main types of ques-

tions used in semi-structured interviews: descriptive, structural, and contrast questions. Descriptive questions ask the informant to describe an experience, place or event. "I have never been to the STD clinic in your region, could you describe it for me?" is an example of a descriptive question.

Structural questions are aimed at discovering how informants organize their knowledge; they

are, therefore interested in uncovering categories or domains. For example, in Guide 3 respondents are asked to list illnesses that can be transmitted through sexual intercourse. From this you will learn which illnesses form part of the domain of illnesses that the informant thinks about when considering sexual transmission.

Contrastive questions attempt to understand exactly what an informant means by a term he/she uses. A contrastive question might ask the informant to clarify the differences between two illnesses already mentioned. For example, we might take the responses to the above question about illnesses that can be sexually transmitted and ask the informant to identi-

Figure 3-1. Example of a Nominal Group Technique

ISSUE PERSON	RANK					BY
	A	B	C	D	E	
Improve Communication between Patient and Provider	1	4	3	2	1	
Improve Women's Access to Clinics		2	3	2	4	
2						
Increase Number of Patients at STD Clinic	3	2	1	3	3	
Improve Communication Materials	4	1	4	1	4	
Decide Between Separate STD	5	5	5	5	5	

Structured Interviewing

For the TIR the most common research method is semi-structured interviewing. This method of interviewing is recommended because it uses an interview guide whereby a lot of information can be collected in a relatively short period of time. Since several interviewers will be involved in this activity, the Guides function as a set of standardized instructions, listing out the topics to be covered and including some wording that can be used to ask questions.

Semi-structured interviewing is different from structured interviewing because although specific wordings for questions are given, inter-

fy the differences between two or more illnesses.

Semi-structured interviewing requires several skills including probing and following leads, and may include other techniques such as free-listing, rank ordering, and the development of taxonomies and scales, all of which will be discussed below.

When probing the interviewer stimulates a respondent to produce more information on a particular topic without injecting the interviewer's ideas into the discussion. The most common type of probe is to repeat back to the respondent what she/he has said and ask for more information. Another way to probe is to use a culturally appropriate non-verbal signal after being given some information, encouraging the respondent to continue expanding his or her idea. In some cultures, nodding or saying "uh huh" are suitable non-verbal signals.

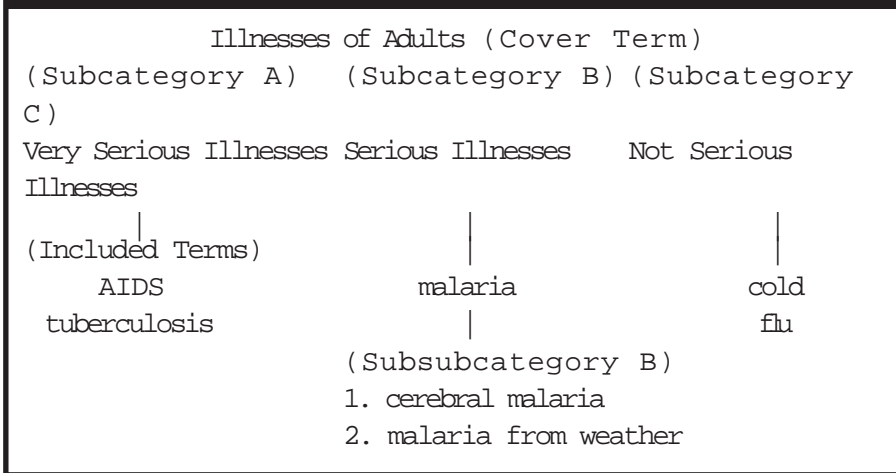
Following leads gives interviewers a way to further explore the responses of the informant. Informants rarely give all the information about an illness episode in a sequence that matches what really happened. Interviewers can help order the information given, like putting together a puzzle, to help informants tell a cohesive story. This same technique can be used to get more detailed information in the informant's own words. For more information on semi-structured interviewing, see Bernard (1988) and Spradley (1979).

D. Obtaining Illness Terminology through the Creation of Free Lists

Free-listing is a technique which asks informants to spontaneously list out the terms which fall under one category, or domain. Guides Two through Four are based primarily on information elicited through free-listing, after which information is sought about each illness listed by the informant. There is a great deal of information that can emerge from a spontaneous list given by an informant. For example, besides noting which illnesses

are contained on the list, the order in which the illnesses are mentioned gives some information on significance, commonness, importance, and experience with these illnesses. By asking many informants to create the same list, the information will also show the variability of experience and opinion within a given research site. For more information on free-listing see Bernard (1988).

Figure 3-2. Example of a Domain and Taxonomic Analysis of Adults



show the variability of experience and opinion within a given research site. For more information on free-listing see Bernard (1988).

E. Domain and Taxonomic Analysis

A domain is a category of terms containing four elements: a cover term (illness of adults); two or more included terms (malaria, AIDS); a single semantic relationship (a kind of illness), and a boundary (there are illnesses which are not adult illnesses). Figure 3-2 below represents how to conduct a domain and taxonomic analysis. This example is taken from an experience using a different version of this manual, the TIR for Community Members in an East African country.

The example shows a domain of adult illnesses where the included terms are malaria and AIDS, TB, colds and flu. The semantic relationship is that each included term is a kind of adult illness and because there are illnesses which are not adult illnesses, a boundary exists.

A taxonomy is a set of categories also organized on the basis of a single semantic relationship. The Guides Two through Four ask for information about different categories of illnesses: sexually transmitted illnesses, and illnesses of the nether area. The taxonomy is "kinds of illnesses affecting the 'nether area'"—a broader term than a domain.

The TIR calls for both domain and taxonomic analyses. In this version of the TIR, Guides Two through Four, questions are posed to elicit information on several categories, or domains of illnesses. The question posed to derive this kind of information is: "Can you tell me the different illnesses affecting the 'nether area'?" Domain analysis allows you to understand the terms included in several categories of illness; taxonomic analysis allows you to understand the internal structure of those domains. For example, within the domain called illnesses affecting the "nether area", you may find that there are some that are more serious, others that are less serious and some that are not at all serious. The subset in which an illness is placed may determine a great deal about the decision-making related to treatment and prevention. For more information on domain and taxonomic analysis, see Spradley (1979).

F. Scales

Scales are a method of ranking several mutually exclusive categories. Scales can be nominal, ordinal, interval, or ratio. Nominal scales are mutually exclusive and do not follow a particular numerical order. In this research, only nominal scales are used to rank perceptions of illness severity. Respondents are asked to characterize an illness by describing it as either very serious, serious, or not serious (Guides Two through Four). In the analysis, simple descriptive statistics can be used to describe perceptions of severity for a particular illnesses. For more information on scales, a useful reference is Pelto and Pelto (1970).

G. Case History

Case history is a method of eliciting information about a particular event in a person's life. In this research, respondents are asked to describe various aspects of a particular illness episode including its symptoms, causes, perceived transmission route, health care decision-making, other treatment, and other behavior. Case histories are then analyzed as examples of personal STD experience. The analysis of "cases" or case histories attempts to discover similarities and/or differences among them. A group of case histories will be compared on several variables, such as descriptions of symptoms, causes, transmission, experiences with the health system, and other treatments sought. While descriptive statistics should not be used to try to quantify these data, patterns can be noted. For more on case frame analysis, see Miles and Huberman (1984).

H. Developing Explanatory Models of Sexually Transmitted Illnesses

The purpose of developing explanatory models of sexually transmitted illnesses is to understand informants' perceptions of illness etiology, timing and pattern of onset of symptom, pathophysiological processes, natural history and severity, and appropriate treatments. Explanatory models are used to describe the process individuals go through to explain, organize, and make choices during an illness episode. Once response to a particular illness episode is understood and fits within an explanatory model, the model in turn can be better understood by examining the larger social context of behavior, for example, the social and economic organization of the setting and dominant religious ideologies. Explanatory models can be constructed for each individual's set of responses but your interest is to find a more generalizable model on which to base programmatic decisions. For this reason, it will be necessary to look for commonalties between respondents!quote explanatory models to develop an explanatory model which applies to a larger

group of people.

Explanatory models will be built by combining the responses of several respondents together and examining the collective views about each illness studied. The challenge will be to look for similarities between several explanatory models of the same illness, and to create a macro explanatory model to closely represent the collective experience with the illness.

In the TIR, this is accomplished by looking at the data from Core Illness Guide Five and the Clinic Guide Nine. By using the information gathered in the five areas listed below, you will be able to construct an individual's explanatory model for a particular illness episode. For more information on the explanatory model, see Kleinman (1980).

1. Illness Etiology

While most of the illnesses under investigation are known to be transmitted through sexual intercourse, their cause or etiology may be perceived differently by informants. Individuals may believe that their illness was caused by misfortune, adversity, a biological agent, spirits or a magical force, or as punishment for "bad" behavior. Individuals may also believe that there are multiple possible causes, only one of which is related to sexual behavior. Since the concept of the incubation period may not be well understood, community members may consider the cause to be the event that occurred closest in time to the onset of symptoms.

2. Timing and Mode of Onset of

Symptoms

In Guides Two through Four, the Core Illness Guide Five, and the Clinic Guide Nine, respondents will be asked to list the symptoms associated with a particular illness in their order of occurrence. Frequently the more common symptoms, such as fever, are noted first. For this reason, respondents may explain that they wait for other symptoms to arise in order to determine the nature of the illness. Thus, it will be important to note not only the list of symptoms and their order, but also the delay between the first symptom(s) and the later symptom(s) that the respondent used to decide what his/her illness was. For example, the first symptom noted in a case of both malaria and STDs may be fever, but

most patients describe waiting for more specific symptoms such as chills or an open wound in the genital region to decide whether they are suffering from malaria or a STD.

3. Pathophysiological Processes

Once the illness is noted, given a name, and a cause is determined, a person decides whether or not the illness will require treatment. In this research, you will be interested in the decision-making that occurs around treatment seeking, and the continuation or halting of sexual behavior. It will be useful to learn what causes the patient to seek treatment (e.g. pain, discharge, or abscesses) and the delay between self-detection of symptoms and initial treatment seeking. It will then be important to note who the informant goes to for advice about treatment options, which treatment options he/she selects, and at what point he/she consults a medical professional.

4. Natural History and Severity

Informants will likely be able to describe their experience and impression of the natural history and severity of the illness, under circumstances when treatment was and was not available. This will include the effects of the illness on the informant's life if no treatment is received, versus the effects or costs of seeking treatment. It will also show the respondent's opinion of how important treatment is in reducing the severity of an illness compared with curing it.

5. Appropriate Treatments

Finally, informants will be able to discuss the various treatment options available to him/her and the appropriateness of each. The respondents of Clinic Guide Ten are clearly seeking treatment advice from a medical professional. However, it is not obvious whether this was the first treatment sought and whether other treatment options were tried previously and considered equally, less, or more efficacious. These distinctions are important to understand.

A. Introduction

The Research Guides were prepared using a list of programmatic goals and objectives which were developed in conjunction with AIDSCAP technical personnel. There are twelve Research Guides, some of which are divided into sections. Each Guide represents a group of questions on a topic or domain.

Most of the Guides are designed to be administered with sex workers and their clients. Guide Eight is meant to be administered with Health Workers.

All the Guides include instructions to the interviewer and specific questions to be posed. In addition, the interviewers should be instructed to probe for additional information and to follow leads from the information given by the respondent in answer to specific questions. Figure 4-1 shows recommended informants for each guide.

B. Guide Zero

Part A of this Guide was designed to be administered at the start of each interview. It describes the purpose of the research and asks

for informed consent from the respondent to participate in the research. This Guide should be amended, depending on instructions from the local Committee on Human Volunteerism (see Chapter Two, Section L for further discussion on this subject). Part B of the Guide collects basic sociodemographic background information from informants who agree to be interviewed; details related to the interview, including interviewer identification and a brief description of the interview setting, are also included.

All persons interviewed must have Guide Zero, Part A on informed consent administered to them.

Figure 4-1. Recommended Informants for Each Guide

GUIDE #	RECOMMENDED INFORMANTS
Guide Zero	All people interviewed
Guide One	Persons knowledgeable of the local sex trade
Guide Two	Diverse sex workers and clients of com-
mercial sex	
Guide Three	Diverse sex workers and clients of com-
mercial sex	
Guide Four	Diverse sex workers and clients of com-
mercial sex	
Guide Five	Informants identified in Guides Two
through	
STD-	Four who have had experience with an
	related illness
Guide Six	Sex worker clients identified at sex trade
	establishments
Guide Seven	Brothel owners, administrators, pimps,
madames	
Guide Eight	STD clinic workers and pharmacists
Guide Nine	Patients visiting STD clinics
Guide Ten	Sex workers identified in Guides Two
through	

C. Guide One

Guide One, which can be administered to key informants or adapted to a focus group setting, represents an important starting point for a study that concentrates on the commercial sex setting. It includes a series of questions intended to reveal the nature and structure of different kinds of prostitution that

exist in the community. Informant sampling for later interviews should be based on the findings from these initial interviews.

Persons knowledgeable of various aspects of the local sex trade should be used for this inter-

view.

D. Guides Two through Four

Guides Two through Four should be treated as a group. These four Guides generate free-lists of illnesses affecting the "nether area," illnesses thought to be transmitted through sexual intercourse (as contrasted with those "caused by" sexual intercourse, which is a different question) and illnesses associated with specific STD symptoms. The Guides were specifically designed in an order which would start with a relatively broad category (illnesses affecting the "nether area" in adults) and become increasingly specific and narrow as the interviews progress. Each Guide should be treated as one interview, so that each informant is only asked to generate one list at a time, and is asked to discuss the importance, symptoms, transmission, causes and affected gender of only the list that he/she has generated. Each interviewer should administer each of the four Guides to five (5) different informants. At the end of each interview,

a matrix should be created, clearly summarizing the illness names, symptoms (in order mentioned), causes, and affected gender. Figure 4-2, is an example of a matrix with data from an East African country.

The supervisor should sensitize the interviewers to the idea that cause and transmission are very different issues and questions about these areas generated different information. Probing is important in order to generate useful information for programmatic purposes.

After each interviewer has administered Guides Two through Four, the technical lead should compile a master list of all illnesses generated from all the interviews. This master list should include the number of times each illness was mentioned by informants, so that a total can be obtained. From this master list, a new list of core illnesses can then be derived. The technical lead can use his/her own judgment about the criteria for deriving the list of core illnesses. The suggested criteria is as follows: an illness is selected (1) if the symptoms description corresponds to symptoms of biomedically defined

Figure 4-2. Matrix to Summarize Data from Guides Two—

SYMPTOMS, CAUSES AND GENDER OF ILLNESSES AFFECTING THE "NETHER" AREA			
ILLNESS	SYMPTOMS	CAUSES	GENDER
Chindoko	1. gets fever in the first days 2. pain when urinating, sores all over the genital area 3. the sores produce pus 4. the person smells bad	1. doing sexual intercourse with a partner who is already infected 2. intercourse with "prostitutes"	1. for women 2. for men
Chisonono	1. fever in the first days 2. discharges pus and feels pain when urinating	1. witchcraft 2. intercourse with "prostitutes"	1. for men 2. for women
Mabomu	1. fever during the first days 2. then boil develops on one side of the groin. When boil breaks another develops on the other side, 3. they keep on alternating up to when one gets effective treatment	1. intercourse with "bar girls"	1. for men 2. for women

STDs or (2) if it is believed to be caused/transmitted through sexual intercourse.

1. Guides Two and Three

Guides Two and Three have only one section each. These two Guides all have instructions for the interviewer, steps to be followed, and specific questions to be posed for informants. The first question asks for the generation of the free-list of illnesses, within a particular domain. The domain of Guide Two is restricted to "illnesses affecting the nether area." The nether area refers to the area including and around the genitals; front and back sides of the body. Think of the nether area as being below the waist but not extending down the legs beyond the thighs. A local colloquialism can probably be used to make the idea of the "nether area" clear to your interviewers and informants. For example, in the United States one might say, "below the belt." A visual prompt, such as pointing to the area below the waistline, may also be appropriate.

The rest of the questions will then be posted about each of the illnesses given on the list. This will include a list of symptoms associated with each of the illnesses, and the order in which these symptoms appear. It is of interest to learn whether community members think of an illness as having a sequential series of symptoms or whether they view each additional symptom as a separate illness.

Other questions are asked about asymptomatic illness, the perceived seriousness of the illness, cause, mode of transmission, affected genders, implications for infertility, benefits of acquiring the illness, negative consequences (other than infertility), prevention and treatment.

The final question on each of these Guides asks the informant if he or she has any personal experience with any of the illnesses. The purpose of asking this question is to identify a group of key informants who might be willing to be interviewed about the particular illness with which they have had experience.

Possible Informants: Any diverse set of community members, met haphazardly or intentionally, in community settings. For example, a man sitting on his porch, or a woman walking to get water, a young man at a bar, a tailor at his shop, an herbalist in her home or a person waiting for a bus. Adults ranging in ages should be interviewed.

2. Guide Four

Guide Four differs from the first two in the method used to obtain information. In Guides Two and Three the informant uses the free-listing technique to define an illness list and an associated symptoms list for each illness. In Guide Four, five individual symptoms are described to the informant and she/he is asked to name illnesses which produce these symptoms. In other words, the informant is free-listing illnesses for a single, fixed symptom.

Guide Four consists of several parts, which all may or may not be utilized during the interviews. Part A asks the respondent to generate free-lists of illnesses which have specific symptoms. There is a form included with the Guide which should be used as directed to generate the lists of illnesses with which the respondent is familiar.

Once the respondent has generated lists of illnesses associated with specific symptoms, the interviewer should move on to administer the parts of Guide Four (B-F) which relate to specific symptoms.

Possible Informants: Same as Guides Two through Three.

E. Guide Five

Guide Five utilizes the list of core illnesses generated from Guides Two through Four, and asks for in-depth knowledge of each illness. The technical lead should caution interviewers to start again for each illness in the sense that they should not accept information on an illness given to them previously by an informant. If at all possible, it would be preferable to administer these guides to the key informants who were identified through the administration of Guides Two through Four. The interviewer should use his/her judgment about the number of illnesses discussed per informant, taking care not to tire the informant. It may be useful to use the general rule of five (5) informants per illness. If the illness affects both genders, it will be necessary to have both female and male interviewers conduct interviews with informants. Depending on the length of the list of core illnesses, the time to do this will vary.

The first part of Guide Five requests personal anecdotes about core illnesses. The depth of the information will depend on the quality (and

experience) of the informants. The technical lead should encourage the interviewers to seek out "key informants" who might be able and willing to provide their personal experience for this purpose.

The second part of Guide Five requests "basic information" related to the core illnesses. This part will only be used if no informants with personal experience about a particular illness can be located.

Possible Informants: "Key Informants"—prior informants who were either particularly knowledgeable, or who appeared to have experience in the subject, or who are open to discussing the subject. If too few subjects are available, recruit new informants who have experience with one or more of the core illnesses.

F. Guide Six

There are three parts to Guide Six. The first part is an intercept interview, which is designed to be used in a situation where clients of SWs can be easily identified (bar, brothel, or clearly associated with street-based SWs). Because it is assumed that clients will not be inclined in these settings to take much time to respond to questions, the Guide has only a few questions that should take about 20 minutes to complete. The second and third parts of the Guide can be used with clients who agree to a later, more in depth interview that will be conducted at a location removed from the commercial sex environment. The second part is an in-depth interview and the third part a brief questionnaire to collect sociodemographic data.

Guide Six should be administered to individuals identified at establishments or places where commercial sex transactions are common-place.

G. Guide Seven

This Guide aims to elucidate the nature of relationships that exist between sex workers and their managers (brothel owners, pimps, madames, etc.), the perceived importance of STDs to the sex trade, the role of commercial sex managers in STD treatment of SWs. This interview also addresses the potential interest of these man-

agers in efforts to improve STD prevention and control services.

A variety of individuals responsible for business aspects of sex trade should be interviewed with Guide Seven.

H. Guide Eight

The target group for Guide Eight is different than the other Guides, for this Guide was developed to learn about health worker knowledge and attitudes related to sexually transmitted illnesses. The Guide is divided into two parts. The first part asks for the generation of free lists of local language names for illnesses and symptoms transmitted through sexual intercourse. As with informants from the community, consensus on local language names from health workers can not be anticipated.

For this reason, several different informants should be sought. Medical texts and dictionaries written in the local language should also be consulted but not used exclusively to generate these lists.

The second part of Guide Eight asks for other information related to sexually transmitted illnesses. This guide should be administered to several health workers who are familiar with the subject.

Possible Informants: Clinic workers, preferably those providing STD treatment services; doctors, nurses, assistants; also obstetrical workers, internists and pharmacists.

I. Guide Nine

Guide Nine will be used with patients visiting an STD clinic. This Guide is designed to elicit symptoms, causes, transmission and decision-making about STDs from actual patients. This instrument should be administered at an STD clinic to approximately 100 male and 100 female patients.

There are three parts to Guide Nine. The first part may be administered during the waiting time between registration and the actual visit. The second part will be filled out by the provider during the visit. The third part will be administered after the patient has seen the provider and has

Field Procedures for Data Management

A. Interviewer Notebooks

Since the primary form of data collected by the TIR are words from interviews, the task of data management in the field is managing the interviews. The technical lead is ultimately responsible for this process. However, each interviewer is also responsible for managing his or her notebooks, and the data analyst should be involved in creating electronic summaries.

It is the job of the technical lead to shuttle between field sites and the office base. She/he must schedule visits to the field and pick up a set of Fair Notes on each visit. Only these final notes are collected. At the completion of the field work, you may decide whether to destroy the raw field notes or let them remain the property of the interviewers.

During the intensive first days of the research, the technical lead should visit each site every second or third day. Interviews should not be allowed to pileup; typing up the interviews should begin as soon as possible.

The Fair Notebooks of interviews form the basis of the entire study and will be needed for checking even after the interviews are typed into the computer. The key to managing the notebooks is to be methodical and organized. A few suggestions are given below.

- 1) Technical lead—be sure you have enough field supplies i.e. notebooks, pens, pencils, pencil sharpeners (often razor blades) and erasers in the field. Use bound, hardcover notebooks which are durable, but spacious enough to encourage the interviewer to thoroughly expand on the interviews.
- 2) Technical lead—agree with the interviewers that each book of Fair Notes should contain sets of interviews corresponding to the time between supervisory visits. Better to receive a steady stream of interviews, contained in more notebooks, than to stuff too many interviews into too few notebooks.
- 3) Interviewers—keep the same interview in one physical book, don't spill over into two notebooks.
- 4) Interviewers—label the inside cover of each book with your name and which Fair Notebook number it is.
- 5) Interviewers—carefully keep track of these interviews. The first several pages of each notebook should contain a table of contents which describes the interviews contained in the book. The table of contents should look like a matrix (see Figure 5-1) and include the following information: Interview ID which is

Figure 5-1. Example of Table of Contents in a Fair

Interview Pages	Date	Location	Name	Sex	Guide	Time
ID	(Mo/Day)					
HA01	7/12	Village 1	M. Asidi	M	1	2:30-3:30 3-5
HA02	7/13	Village 2	S. Joni	M	1	8:00-9:45 6-11
.....						

¹The actual name of the respondent will be shown in only two places. This is in the body of the interview (Fair Notes) and in the Table of Contents of the Fair Notebook. The informant's name is needed here so that the interviewer may return to the informant for follow-up. To maintain confidentiality, the typist should be instructed to replace the name

made up of the interviewer's initials and the number of the interview, in sequence (for example, HA49, which was the 49th interview conducted by interviewer HA); the day and month of the interview; the location of the interview (i.e., which community is it in); the name of the informant¹; the time the interview began and ended; and the pages in the Fair Notebook on which the interview is recorded.

- 6) Technical lead—Once you have retrieved the notebooks from the field, but before they are turned over to the typist, label the spine of each Fair Notebook with the interviewers initials and the book sequence number (1 to n). Use the labels or white paper and tape to designate each notebook. The effect of labeling the outside of the notebook is to make the information inside more accessible. The better organized the technical lead is about labeling and keeping these books available, the more he/she will be able to refer back to them for cross-checking and supervising the work of the typist. It is much easier to label and organize right from the start than to have to go back and do it later.

B. The Field Interview Log Book

Each interviewer should be equipped with one Field Notebook which contains only a master list of the interviews conducted. There is a practical reason for this. With the quick pace of interviewing, and the rapid collection of Fair Notes, it is better that the interviewers have a special book which contains a complete list of interviews. Real trouble begins when one loses track of the interviews.

Each book of Fair Notes must have a few pages, in the beginning of the book, that are used as an Interview Log for that particular interviewer. The Interview Log in the Fair Notes will be taken from the interviewers. Therefore, it is important that the interviewers have a master list in a single book which stays with them in the field.

C. Optional Informant Log

We recommend that the interviewers record the informant's name in the Field and Fair Notebooks simply for its utility in working with some individuals several times during the field work. The design of this research is such that no single individual or small cadre of individuals should be unduly over-represented. While keeping an Informant Log would allow the separate interviews from the same informants to be linked and reviewed more holistically, this depth of analysis has not been included in this version of the TIR.

D. Typing Interviews into the Computer

Once collected from the field, books should be taken to the typist. The typist is a key individual whose almost constant efforts will be needed to type in the interviews and manage the word processing data files which have been created. A one page register should be taped to the desk of the typist, showing which set of Fair Notes are in the typist's hand and whether they have been completely typed in and printed out. An example of such a Typists Register is shown in Figure 5-2.

Figure 5-2. Example of Typists Register

Fair Nbk	Interview IDs	Date Collected	Handed In to Typist	Finished Typing	Printed Out	Picked Up
HA1	HA01-11	4/22	4/23	4/24	4/24	4/25
BN1	BN01-13	4/22	4/23	4/27	4/28	4/29
MM1	MM01-15	5/11	5/11	5/13	5/13	5/14

Once the interviews in a book of Fair Notes are typed into electronic files and printed out, they again fall into the hands of the technical lead. The printout of a set of interviews needs to be reviewed by the technical lead who must check if the interviews were:

- ◆ Typed in accurately (there are usually minor, accidental omissions, sometimes whole sections)
- ◆ Conducted in as thorough a manner as expected. In other words, are the interviews correctly following the guides and do they record all the necessary information?
- ◆ Consistent (for example, in looking at the same informant in two interviews, does the background data vary?).

These three points are quality control issues. They must be scrutinized during the field work. Questions will arise that must be answered by the interviewers. The technical lead should ask these questions during visits to the field.

E. Developing the Field Illness List

The Field Illness List forms the foundation of the TIR and must be produced very early in the research. Only by learning to use local language illness names can progress be made toward a more in-depth understanding of individual illnesses.

As soon as the interviewers have conducted the five interviews for each of the Guides Two through Four, the technical lead and interviewers

should sit down together to produce the Field Illness List. This very important meeting should be held in the field during the second week of field work.

At this point, at least eighty interviews should be in hand. The technical lead should have all the

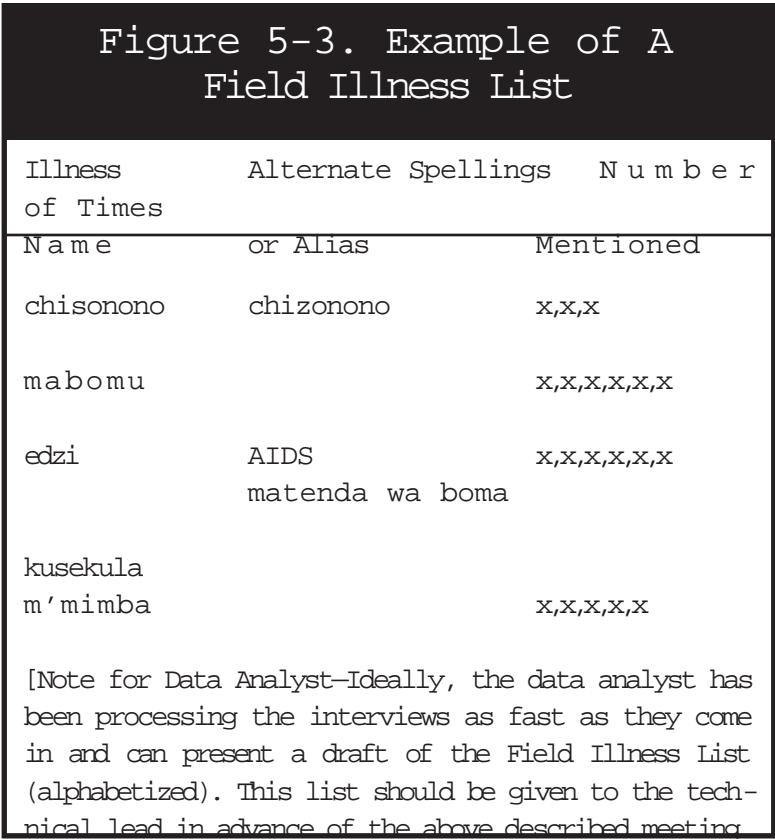
Fair Notes available, and the interviewers should have all their Field Notes available. These materials will be used to compile a Field Illness List and then a Core Illness List.

An example of a Field Illness List is shown in Figure 5-3. The list has the illness names written along the left-hand side of the page and leaves several blank rows between each name. Alternate spellings and/or alias names should be noted next to the first name as they are found in successive notes.

On the same row as each illness name, put a check-mark for each time it is mentioned by an informant. Make sure to include the first mention, the interview in which the illness name is first obtained, with a check-mark. This builds a frequency of mentions.

It is likely that your informants and your interviewers are sometimes guessing at the spelling of some illness names. Don't anguish over slight spelling differences if it appears they represent the same illness (for example, substituting a "z" for an "s"). Interviewers should be able to work out minor spelling differences on the spot.

Sometimes there will be illnesses with similar names but very different symptoms. Work with the interviewers to find these cases and be sure to list the illness names separately if the symptoms suggest they are separate illnesses. If in



This provides a working tool for the technical lead.]

doubt, list the names separately.

In addition to alternate spellings, and different illnesses with similar names, there is another possible complication to making this list. There may be some illnesses which have multiple names. In one East African Country, for example, there are three names used for Acquired Immune Deficiency Syndrome: *edzi*, *matenda wa boma*, and AIDS. Note all alias names in the Field Illness List to avoid confusion and redundancy.

At this point the team will have developed a complete Field Illness List. There is no way to predict how large a list this will be. However, it is quite likely that between 20 and 100 illnesses will be named. This is too large a number to investigate each in detail. Also, this complete list will contain many illnesses which are not of interest to this investigation. Therefore, the next step is to develop a Core Illness List. The Core Illness List will be the basis for further investigation.

through sexual intercourse.

- ◆ Include illnesses mentioned five or more times by informants.

These simple criteria allows a quick screening of the illnesses for those most clearly related to sexually transmitted diseases.

The Core Illness List should contain the same information for those illnesses selected as the Field Illness List. This includes the first name given, alternate spellings and aliases, and the number of times the illness was mentioned by informants. In addition, the Core Illness List should include the symptoms of the illness as mentioned by informants, and the order they were mentioned (which should be the order in which they occur in the course of the illness). This list will eventually be compared to the information obtained through the administration of the Core Illness Guide Five.

F. Developing the Core Illness List in the Field

The Core Illness List is a subset of the Field Illness List which contains the study population's lexicon for STD related illnesses. The Interview Guides have been designed to elicit, from various angles, local illness categories that may correspond biomedically defined STDs. The list of illnesses elicited from informants will initially be quite broad, including all illnesses that informants can think of that: (1) affect the area of adult persons bodies between the waist and the knees, (2) are considered to be sexually transmitted, and (3) have symptoms similar to those associated with STDs. Thus, local illness categories that correspond to biomedically defined STDs are likely to be clearly reflected in both the total number of illnesses mentioned and in how frequently they are mentioned.

Nonetheless, the technical lead and the interviewers should arrive at a set of criteria for deriving the Core Illness List. Some suggested criteria are given below:

- ◆ Include illnesses described as having symptoms corresponding to biomedically defined STDs
- ◆ Include illnesses believed to be transmitted

A. Introduction

This chapter offers guidance on how to approach data analysis for the TIR. It is not intended to be a rigid prescription for how to conduct the analysis phase of the research. Rather a few more detailed examples of how one could systematically approach data analysis are explained. This is done for several key Guides but not all. It is assumed that after reading this chapter, the technical lead, field supervisor and data management team will be able to develop suitable approaches for analyzing all of the results.

Qualitative data analysis uses words as the basic unit of analysis. Documentation and the process of interpreting information starts with Field Notes. When Field Notes are further expanded into Fair Notes this is a further step towards interpreting data. Interviewers who add their observations of what happened during the interview or comment on a response given are offering information useful for interpreting the results of that interview.

The next step is to type Fair Notes into a computer. Qualitative data analysis will be used to organize, summarize and display the data in an organized fashion. Through this process broader interpretations can be made and used to answer programmatic questions set forth by the TAG.

Several general analysis processes are described in this Manual. In all cases, data entry and analysis begins as soon as Fair Notebooks return from the field. The process starts with how to handle raw data followed by how to code the data for entry into the computer. Once this is finished, several suggestions for how to analyze the electronic version of the data are offered.

Using Figure 1-5 and Sections J through Q in this chapter research team could summarize how analysis of different pieces of information are used to answer programmatic questions. Of course, for each TIR activities the appropriate analysis steps will have to be customized just as

the programmatic questions were, according to their usefulness. The analyses offered here are described in a step-by-step progression.

Using a computer is not necessary for qualitative analysis but if used sensibly, it is a useful tool for making information more accessible and allowing a flexible approach to data analysis. It also is not necessary to develop an electronic coding system and use a database-type software program to sort and count this information. Many ethnographers still prefer to work with written notes or typed notes with simple copying and filing systems to be able to gather together all responses to a given question.

In this Manual, the use of a database-type program is described but not required. In order to use the computer effectively, it is suggested to hire a data analyst, computer programmer and data clerk as members of the research team.

Coding the data is appropriate whether or not a computer is used but it is absolutely critical to transform textual information to be managed electronically. The coding format will determine the speed with which the data is entered, as well as its organization and availability for analysis.

We suggest that a Codebook be developed showing the link between the text in the Fair Notebooks and the functional computer data files. Although a sample Codebook is included here, the actual Codebook used should be developed to accommodate the data collected and meet analysis needs. This means that codes must also be able to link responses to particular programmatic questions. There may be a need for more variables than those suggested by the example. For example, three "transmission" variables may not be enough. Therefore, the software selected must be flexible enough to allow file structures to be easily modified while preserving the data that has already been entered.

Most of the analysis techniques shown below can start by using the Fair Notes before they are typed. However, typed notes consolidate the original information into fewer pages of printed text and will make copies more accessible.

B. Analysis During Data Collection

It is essential to begin data analysis during the field work. One reason is that early in the activity, subsets of illnesses must be identified for further investigation. This must be done in the field and can easily be accomplished by using a combination of Fair Notes and Field Notes con-

taining the responses to Guides Two through Four.

Furthermore, while data analysis is proceeding gaps in information may be identified. If this can be done quickly, adjustments to the Guides can be made to try to answer new questions or clarify information. It is also useful to prepare preliminary illness models and then have the opportunity to verify them with informants before leaving the field.

One of the risks of rapid research methods is the possibility of mistakenly identifying patterns

Figure 6-1. Sample Codebook used for the Electronic Log

Codebook: INTLOG.COD		Data File: INTLOG.REC		
VARIABLE				
#	NAME	LENGTH	TYPE	DESCRIPTION
1	INTNO	3	N	Interview Number (Unique-assigned)
2	IVIEW	2	C	Interviewer Initials
3	INTID	4	C	Interview ID Number (Use Interviewer initials and sequence number e.g. MA01)
4	FNOTES	1	N	Which book of Fair Notes?
5	DAYI	2	N	Day of Interview (1-31)
6	MONTHI	1	N	Month of Interview (1-12)
7	NAMEI	30	C	Name of Informant
8	AGEI	2	N	Age of Informant
9	SEXI	1	N	Sex of Informant 1=Male, 2=Female
10	TYPEI	2	N	Type of Informant AM=Adult Male Informant AF=Adult Female Informant TH=Traditional Healer HW=Health Worker SO=Shop Owner Others
11	LOCAT	2	C	Location Interview was conducted in (Use a 2-character code)
12	MINSI	3	N	Elapsed Interview Time in Minutes
13	INFIELD	2	N	Day Fair Notes handed in from field
14	HAND	2	N	Day Fair Notes handed to typist
15	TYPED	2	N	Day Fair Notes Completely Typed
16	PRINT	1	C	Whether Interview has been printed N=No Y=Yes
17	ISSET	1	N	Interview Guide Set Used (1-6) 1=Illness Affecting Adults 2=Illness Affecting "Nether Area" 3=Illnesses transmitted though sexual intercourse 4=Illnesses with Specific Symptoms 5=Core Illnesses: In-depth Interview 6=Service Delivery 7=Communication 8=Guide for Health Workers

in the data when none exist. Thus an iterative process, where new information results in new questions to be further explored during the field work, is a useful way to confirm the validity of information.

C. Data Analyst, Computer Programmer and Data Clerk Positions

It is recommended that several full-time staff be hired for the duration of field work and through completion of the report. These individuals should have a broad range of skills that will be helpful to the technical lead. Together the data analyst, computer programmer and data clerk form a data management team and must be able to:

- ◆ Assist in the development of codes after reading interview Fair Notes.
- ◆ Code the interview data into a computer compatible format.
- ◆ Input these codes for each informant's responses.
- ◆ Generate computerized lists using database software.
- ◆ Print out various different kinds of sorted lists as requested.
- ◆ Link and compare lists through relational database techniques.
- ◆ Produce summaries as suggested by this Manual.
- ◆ Cut and paste interviews in a new order.

As with any research project, the TIR will have peak data collection periods. Following these, a team of three data management staff will be able to more rapidly process information as it is submitted. At some points during the TIR, rapid data processing is needed (e.g. following Guide Five). This can save substantial amounts of time for the overall implementation of the activity. We estimate that for every week the data collection is fully supported by three persons, you save three weeks of data processing time after field work is completed.

D. The Electronic Interview Log

The Electronic Interview Log is a computerized version of the Interview Log Books. The Electronic Interview Log is primarily a field management tool used to keep track of how many interviews have been conducted, and which Guides have been administered. A "record" is entered into the computer for every interview conducted. A suggested codebook for the Electronic Interview Log Book is shown above, in Figure 6-1. This example is taken from an experience using the TIR for Community Members, not the TIR for the Setting of Commercial Sex.

The job of compiling and entering this information into the computer is the responsibility of the data management team. The field supervisor ideally will receive daily up-dates of this list and can use it to monitor the progress of the inter-

views.

E.

Figure 6-2. Codebook for Computerized Illness List

Codebook: ILLNESS.COD			Data File: ILLNESS.REC	
VARIABLE				
#	NAME	LENGTH	TYPE	DESCRIPTION
1	ILLID	3	N	Illness identification number
2	WORDL	30	C	Local language illness name
3	WORDE	30	C	English language illness name (or illness descriptor)
4	WORDO	30	C	Other language illness name (French/Spanish/Arabic/Russian)
5	CORE I	1	C	Whether the illness is include

Figure 6-3. Example of an Alphabetized Illness List

Illness	Local Language	English
Translation	Other	Major*
ID.	Illness Name	Language
Translation		
3	Chindoko	Open sores on genital
2	EDZI	AIDS
4	Kamwazi	Stools with blood
1	Likodzo	Bilharzia
6	Mambomu	Buboes
5	Mtima	High blood pressure
7	Nsana	Back ache
* In countries where more than one language is widely used, the translation should be into a logical major language. For example, in Haiti the lingua franca maybe		

Figure 6-4. Codebook for Computerized Symptom List

Codebook: SYMPTOMS.COD			Data File: SYMPTOMS.REC	
VARIABLE				
#	NAME	LENGTH	TYPE	DESCRIPTION
1	SYMID	4	N	Symptom Identification number
2	SYMPL	30	C	Local language symptom name
3	SYMPE	30	C	English language symptom name (or illness descriptor)
4	SYMPO	30	C	Other language illness name

Preparing the Data from All Guides

The technical lead must thoroughly familiarize him/herself with the content and structure of interviews. The interviews must be read and re-read. After the first several interviews, patterns will begin to emerge. It is these patterns and a close examination of the programmatic questions that form the basis of a coding system.

For each set of interviews, the technical lead, field supervisor and data management team must identify a set of codes. Once this is done it will be the job of the data management team to convert the textual information into a more streamlined electronic form. What follows are several sections offering suggestions for coding and analyzing several selected Guides. The analysis processes included here will hopefully be used as examples for how one might conduct data analysis rather than as a rigid prescription for how to proceed.

F. Computerized Data from Guides Two through Four

Following the instructions on note-taking (see Chapter Five, Section A), the interviewers will present these responses in a table format in their Fair Notes. Next, two simple lists can be developed:

- ◆ A Computerized Illness List containing local language illness names and unique identification numbers.
- ◆ A Computerized Symptom List containing local language symptom names and descriptions while using unique identification numbers.

A member of the data management team should then separately code the illness names and symptom descriptions or phrases before data entry. Codes are nothing more than an efficient way of storing data. It would involve a great deal of time to write the full illness or symptom phrase each time it was entered into the computer. Therefore, codes for all named illnesses and symptoms must be selected.

Each entry includes the local language terms, translations into another major language (presumably that of the health care professionals). If comparisons between countries is desirable, an entry to accommodate the English translation is recommended. Next, each interview must be coded.

G. The

Figure 6-5. Sample Summary Form A, Guides Two through Four

INTID_____		GUIDE_____		Number of Illnesses Mentioned									
SEQ	Illness	Number of	Symptom Codes (Ranked by Time of Onset)										
ID	Code	Symptoms	S1	S2	S3	S4	S5	S6	S7	S8	S9		
S10	S11	S12											

Computerized Illness List

The Illness List contains a line of data (a "record") for each illness name mentioned in the interviews. This is exactly the same as the Master Illness List, which was obtained in the field from the administration of Guides Two through Four. Each illness name entered into the list is given a unique "Illness Identification Number" or illness ID, beginning with the number 1 and increasing with each addition to the list.

This list will grow rapidly for the first few interviews and then more slowly after that as repeating illness names emerge in following interviews. The TIR reinforces this pattern by design, since the progression of Guides specifically focuses informants on sexually transmitted illnesses and their symptoms.

It is not necessary to enter the illness names in

alphabetical order. Since the list will continue to grow over the first few weeks of research, the illness ID numbers will not correspond to the alphabetical order. However it will be necessary to be able to print out alphabetized lists afterwards. A suggested format is presented Figure 6-2 using the codebook for a file called ILLNESS.REC. A sample printout is shown in Figure 6-3.

The data management team should begin building this list as soon as the

Fair Notebooks are brought in from the field. These notebooks should be shared between the typist, the field supervisor and the data management team. One option for data entry is to indicate which illnesses are "core illnesses" by using a no/yes (0/1) variable.

H. The Computerized Symptom List

Figure 6-6. Sample Codebook for Summary Form A, Guides Two

Codebook: INT14PTA.COD Data File: INT14PTA.REC LRECL=53

VARIABLE

#	NAME	LENGTH	TYPE	DESCRIPTION
1	SEQID	4	N	Unique record sequence number
2	INTID	4	C	Interview ID
3	GUIDE	1	N	Specific Guide Used 1=Illness of Adults 2=Illness of "Nether Area" 3=Illness transmitted through Sexual Intercourse 4=Illnesses with specific symptoms
4	SGUIDE	1	C	Specific Sub-Guide used (for Guide 4 only, blank for Guides 1-3) A=Pain or urination B=Lower abdominal pain in woman C=Failure to pass urine D=Discharge from vagina/penis E=Itching in genital area F=Warts in genital area G=Buboes in genital area H=Pain and swelling of testicles I=Ulcers/open sores in genital area J=Pelvic pain on sexual intercourse
5	ILLNN	2	N	Number of illnesses mentioned
6	ILLID	3	N	Code of Illness mentioned (see attached list of symptoms)
7	SYMNN	2	N	Number of symptoms mentioned
8	S1	3	N	Code of 1st symptom mentioned (see attached list of symptoms)
9	S2	3	N	Code of 2nd symptom mentioned
10	S3	3	N	Code of 3rd symptom mentioned
11	S4	3	N	Code of 4th symptom mentioned
12	S5	3	N	Code of 5th symptom mentioned
13	S6	3	N	Code of 6th symptom mentioned
14	S7	3	N	Code of 7th symptom mentioned
15	S8	3	N	Code of 8th symptom mentioned
16	S9	3	N	Code of 9th symptom mentioned
17	S10	3	N	Code of 10th symptom mentioned
18	S11	3	N	Code of 11th symptom mentioned
19	S11	3	N	Code of 12th symptom mentioned

Figure 6-7. Sample Summary Form B, Guides Two through

SEQID: _____		ILLID: _____	
Seriousness of illness:	1=Very Serious	2=Serious	3=Not so Serious
Causes of Illness	C1= _____	C2= _____	C3= _____
Transmission	T1= _____	T2= _____	T3= _____
Which Sex is affected?	0=Both	1=Males Only	2=Females Only
Illness cause infertility?	0=No	1=Yes	
Benefits of Illness?	B1= _____	B2= _____	B3= _____
Negatives?	N1= _____	N2= _____	N3= _____
Illness preventable?	0=No 1=Yes		
How prevented?	P1= _____	P2= _____	P3= _____
Can illness be treated?	0=No 1=Yes		
Cosmopolitan medicine treat illness?		0=No 1=Yes	
Traditional medicine treat illness?	0=No 1=Yes		
Had personal experience with illness?		0=No 1=Yes	

The Symptom List contains a line of data (a "record") for each symptom mentioned in the interviews. This list was not developed in the field at all. Each symptom entered into the list is given a unique "Symptom Identification Number" or symptom ID (SYMID), beginning with the number 1 and increasing with each addition to the list.

Unlike the Illness list, the Symptoms List can grow into hundreds of entries. This is partly because there will be a greater number of symptoms described by your informants. However, it will be also large because interviewers should record the exact informant expressions used to describe the symptoms. There will be several hundred entries into the Symptom List. A suggested format for this list is presented in Figure 6-4. Developing the Symptom List is particularly difficult because the list grows quickly. Continuous data entry is required. The file must be sorted alphabetically and printed out on the spot otherwise it is a problem to check the list to see whether certain symptoms have already been listed.

I. Other Computerized Lists

Guides Two through Four ask a series of open ended questions beyond the Illness and Symptom Lists discussed above. For example, the causes of illnesses also require the develop-

ment of a Causes List and perhaps a Transmission List. These, and other lists you will need can follow same format as was described here for the Illness and Symptom Lists.

J. Coding Interviews from Guides Two through Four: Part A

As we have just described, interviews using Guides Two through Four can be entered into the computer using the codes developed in the Illness and Symptom Lists. But what form should the coded data take? A "unit record" (or a line of data) should be entered for every illness named. For example, let's assume an informant names four illnesses during his interview. In this case four lines of data will be entered into the computer, one for each of the named illnesses.

The most challenging aspect of coding these interviews is summarizing the symptoms associated with each named illness. The Sample Summary Form A shown in Figure 6-5 has been designed to simplify coding and data entry. The informant's interview will be broken down into multiple lines of data, depending on how many illnesses are mentioned.

This summary form or something similar can easily be drawn up by hand. It may be most efficient to use a typed version of the interviews to

first record the illness and symptom codes onto this form. Using the alphabetized Illness and Symptoms Lists, previously assigned code numbers can easily be found and matched. One page is usually enough to code all the illnesses mentioned during an interview.

At the top of the form is the Interview ID code (INTID) which links a summary form to a particular interview. The second piece of information identifies which Guide was used. The third piece of information is how many illnesses were mentioned in the interview. This is suggested as a useful summary

piece of information.

The illness and associated symptoms are coded on the lines below. The sequence ID (SEQID) is a unique identification number attached to every line of data entered into the computer beginning with 1 and increasing by 1 for every record.

Next to the SEQID is the Illness Code (ILLID). This is the most important variable to create. You must use an alphabetized output of the computerized Illness List in order to find the unique Illness ID (ILLID) for the named illness.

Figure 6-8. Sample Codebook for Summary Form B, Guides Two

Codebook:	ISSF.COD	Data File:	ISSF.REC	LRECL=63
VARIABLE				
#	NAME	LENGTH	TYPE	DESCRIPTION
1	SEQID	4	N	Unique record sequence number
2	ILLID	3	N	Code of illness mentioned (see attached list of Illnesses)
3	SERIOUS	1	N	Seriousness of illness 1=Very Serious 2=Serious 3=Not so Serious
4	C1	3	N	Code of 1st cause mentioned (see attached list of Causes)
5	C2	3	N	Code of 2nd cause mentioned
6	C3	3	N	Code of 3rd cause mentioned
7	T1	3	N	Code of 1st transmission mentioned (see attached list of Transmissions)
8	T2	3	N	Code of 2nd transmission mentioned
9	T3	3	N	Code of 3rd transmission mentioned
10	SEXA	1	N	Sex affected by illness 0=Both 1=Males only 2=Females only
11	INFERT	1	N	Can illness cause infertility? 0=No 1=Yes
12	B1	3	N	Code of 1st benefit mentioned (see attached list of Benefits)
13	B2	3	N	Code of 2nd benefit mentioned
14	B3	3	N	Code of 3rd benefit mentioned
15	N1	3	N	Code of 1st negative mentioned (see attached list of Negatives)
16	N2	3	N	Code of 2nd negative mentioned
17	N3	3	N	Code of 3rd negative mentioned
18	PRE	1	N	Can illness be prevented? 0=No 1=Yes
19	P1	3	N	Code of 1st prevention mentioned (see attached list of Preventions)
20	P2	3	N	Code of 2nd prevention mentioned
21	P3	3	N	Code of 3rd prevention mentioned
22	P4	3	N	Code of 4th prevention mentioned
23	TRT	1	N	Can illness be treated? 0=No 1=Yes
24	CTRT	1	N	Can illness be treated by cosmopolitan medicine? 0=No

Where the Fair Notes will have a local language illness name, you are trying to use the unique illness ID on the summary form instead.

After assigning the illness code, examine the list of ranked symptoms in the Fair Notes. The rank should be based on when the symptom first appeared, not how long they persist or their severity. Different symptoms persist for different amounts of time, so that symptom #2 may continue even as symptom #3 first appears.

The heading to the right of Illness Code shows symptoms, beginning with the first appearing symptom. Next to the ILLID is a series of symptom codes, beginning with the first appearing symptom (S1). Each illness will have from one to n symptoms. These symptom codes are attached to the specific illness, in one line of data. Use a current, alphabetized output of the computerized Symptom List to find the unique Symptom ID (SYMID) for the named symptom. Where the Fair Notes will have a local language symptom name or description, you are trying to choose a unique symptom ID on the summary form.

As coding proceeds, the typical number of symptom mentioned will become apparent (usually less than ten per named illness). A few cases will have an unusually large number of symptoms. If an informant gives more than twelve symptoms, continue listing symptoms on the line below.

Consider the following example of coding. An informant interviewed with Guide Three: Illnesses Transmitted through Sexual Intercourse, might free-list five illnesses. First, code the illnesses one at a time onto the form. It will be relatively easy to find the illness codes, in a printout of the alphabetized Illness List, because the list will probably be no more than one or two printed pages.

Second, code the symptoms. This will be more time consuming than coding the illnesses because of the longer Symptom List. New symptoms might appear, and they will have to be added to the Computerized Symptoms List and printed out in alphabetical order. Complete as many of the summary forms as necessary to code the interviews on hand. Keep the forms for reference. A data entry codebook for Summary Form A is shown in Figure 6-6.

Guides Two through Four: Part A

Once the data shown in Figure 6-6 has been entered, a few key results can be produced:

Analysis Steps:

- a. A frequency of all illnesses will reveal the most commonly named illnesses. Do informants use any biomedical terms or STD names?

Answer Programmatic Question: 2a.

- b. A frequency of illness from each Guide will further associate certain illnesses to the specific domain (e.g. illnesses transmitted by sexual intercourse). Notice if certain illnesses are mentioned in one Guide but not for others. These are most likely common illnesses not necessarily believed to be transmitted by sexual intercourse. Determine the overlap of these illnesses with others mentioned in the other Guides. At this point you can prepare taxonomies (e.g. tree drawings) for the different domains.

Answer Programmatic Question: 2a.

- c. Calculate the average number of illnesses mentioned for all Guides combined. Calculate the average number of illnesses by mentioned for each Guide, by sex of informant, and by interviewer. Calculate the average number of symptoms for each illness for all guides combined. Calculate the average number of symptoms mentioned per illness by sex of informant.

Answer Programmatic Questions: 4a, 4b.

- d. List out all the records for the most common illnesses. Are there typical sequelae? What is the most common first symptom for core illnesses? Are there branching points? What are typical last symptoms? Construct typical folk definitions of the sequelae for core illnesses.

Answer Programmatic Questions: 2a, 2b, 3a.

- e. Look at the results from Guide Four more specifically by tabulating frequencies of named illnesses by specific symptom named by the interviewer.

Answer Programmatic Question: 3a.

K. Summarizing Results from

- g: Collapse the sequence of symptoms (variables S1 to S12) and look at all named symptoms to produce a frequency of all symptoms, for each illness. Are there differences in frequency of symptoms mentioned depending on the Guide? On the illness? By sex of informant, or by interviewer?

Answer Programmatic Questions: 2a, 3a.

- h: Look at the prevention question more closely from Guides Two through Four. Create a list of prevention strategies. Tabulate frequencies of prevention strategy by illness name.

Answer Programmatic Question: 8a.

L. Coding Interviews from Guides Two through Four: Part B

The second part of coding interviews from this series of Guides One is more straightforward than the first part. A number of follow-up questions are close-ended and a few are open-ended. The responses will require the kind of list building used for illnesses and symptoms (e.g. cause, transmission, benefits of illness, negatives of illness, and how prevented). Sample Summary Form B in Figure 6-7, has ample room for multiple responses, which can be entered after coded lists have been built.

The variables from Part B may either be entered into a separate file, or appended to the file containing the ordered symptoms. Either option works as long as the information from one informant and one mentioned illness can be selected using the unique SEQID. Whether using Summary Form A or B, analyses assume all follow-up questions and corresponding data variables can be accessed for each illness mentioned. The Sample Codebook for Summary Form B is shown in Figure 6-8 below.

M. Summarizing Interviews from Guides Two through Four: Part B

Once this data has been entered, a few key results can be produced:

Analysis Steps:

- a: Cross-tabulate illness ID by the variable indicating whether or not an illness can be transmitted through sexual intercourse. Determine which illnesses are thought to be transmitted through sexual intercourse (at least mentioned once). Look at the percentage of informants which cite intercourse as a transmission mode. Produce lists of other modes of transmission.

Answer Programmatic Questions: 2a, 2b.

- b: Cross-tabulate the "seriousness of illness" (SERIOUS) by the illnesses (ILLID) to develop a taxonomic analysis of the community's perception of the seriousness of illnesses, by separate domains and then for all domains combined (i.e. Guides Two through Four).

Answer Programmatic Question: 3a.

- c: Cross-tabulate illness ID by the variable indicating which sex is affected by the named illnesses. Analyze by sex of respondent.

Answer Programmatic Questions: 2b.

- d: Cross-tabulate illness ID by the variable indicating whether or not the illness can cause infertility to determine which illnesses are believed to be causes of infertility. Analyze by gender of respondent.

Answer Programmatic Questions: 3a.

- e: Produce complete lists of causes, transmissions, benefits, negative consequences to having the illnesses, and prevention measures for illnesses. Analyze these lists by illness and by sex of respondent.

Answer Programmatic Question: 2b.

- f: Cross-tabulate illness ID by the variable coding whether the informant believes the illness can be treated or not to determine which illness are treatable and by whom.

Answer Programmatic Question: 2c.

N. Summarizing Interviews from Guides Five and Six

The Interviews from Guides Five, Six and Nine are the richest of the TIR and this presents a challenge for analysis. This richness means the interviews covered a wider range of topics, and in greater depth. In this version of the manual, a detailed list of suggested analysis steps is provided for Guide Five only.

However, using this information may be more difficult. For example, for each interview a list of who was consulted and the advice received can be developed. It is important to identify the names used to describe certain provider or community member roles, such as traditional healers, fellow SWs, etc. Later on you may find that these are productive groups to work with for delivering program interventions. It also may be useful to focus on illness, management questions such as: "What were the first symptoms recognized?" and "Which symptoms prompt an individual to seek treatment?"

For example, informants will describe the symptoms they experience while having the illness and these can be coded in a similar way to the responses in Guides Two through Four. It is sensible to return to the Master Symptom List and add new symptoms, or descriptions of symptoms, and print out a newly alphabetized symptoms list to work with. Code and enter core illness interview data on illnesses and associated symptoms into the same data file (The Illness/Symptom Sequence File) containing the data from Guides Two through Four. You may need to modify the file to handle a longer list of symptoms.

Depending on the length of the Core Illness List, it is possible to have only a few interviews for each illness. Summarizing electronically is still a useful tool. It may only require extracting a paragraph from each interview on a particular illness and laying them out on a single page and producing a printout for review. This display of information at-a-glance makes it possible to look at what several informants had to say about the same key points. It is up to the field supervisor or technical lead to summarize these data.

Stratification by illness is not always necessary or desirable.

Analysis Steps:

- a: Determine which symptoms are recognized first for each illness. What are the specific sequelae associated with each illness.
Answer Programmatic Questions: 2a.
- b: Which symptoms prompted these individuals to seek treatment? Where do they fit in to the series of symptoms? Early, middle, late?
Answer Programmatic Question: 2b.
- c: Build decision-tree models of how and where community members sought treatment.
Answer Programmatic Question: 2c.
- d: Build lists of who is consulted for advice (e.g. friends, parents, traditional healers).
Answer Programmatic Question: 2c.
- e: Summarize the informant's partner notification behavior.
Answer Programmatic Questions: 5a - e.
- f: Where did the informants go for services? Is there a clear preference for using either the traditional or cosmopolitan health system? What factors influenced their decisions to use the health service they chose? How were they treated by different providers? What kinds of things do they remember being told by providers?
Answer Programmatic Questions: 2c, 3e&f, 3a-f, 7e.
- g: Did most of the informants abstain from sex during their illness? What about during treatment? Did they appear to comply with the treatment regime? Did many of them change their sexual behavior after diagnosis, treatment and cure? Did many mention the use of condoms?
Answer Programmatic Questions: 3c, 6a-c.
- h: Carefully summarize and contrast the experiences for male and for female informants. What are the major differences that come up? Develop folk definitions of illnesses for each sex separately.
Answer Programmatic Questions: 2b&d, 4d.
- j: How many informants changed their behavior

Preparing the Report

A. Defining the Audience

The TIR instrument is designed to be an applied social science research activity to provide concrete answers to the programmatic questions defined by the local TAG. As such the report should be written in a manner that is understandable and useful to the various types of people who will read and use the report. A practical approach might be to think of each of the disciplines of the TAG members and groups doing STD services and communication work and think how to present the information to them that is easily understood and useful. The report should be structured so that readers can navigate easily through it but using a table of contents and section headings. Simple graphic formats and tables can be used to present information clearly and concisely.

B. Creating an Illness Dictionary

The first job of the social scientist will be to prepare an Illness Dictionary from the data. This dictionary will serve as the primary lexicon of the study population's experiences with STD related illnesses. The dictionary will have two parts. Part One will consist of the entries for the local language illness names; Part Two will consist, in alphabetical order, of the closest English equivalents as possible to the local language illness terms. The dictionary will include all the STD related illnesses which are named and described by study participants, and will include the following information.

- ◆ alternative spelling(s),
- ◆ English equivalents (as close as possible to indigenous concepts),
- ◆ probable equivalent biomedical term or syndrome,
- ◆ symptoms (in order of occurrence),
- ◆ causes,
- ◆ sequelae where appropriate,

- ◆ persons affected,
- ◆ outcome if untreated,
- ◆ related illnesses, and
- ◆ number of times mentioned (by gender) in the data set

It will be important to include all named illnesses, whether or not they seem to correspond to a biomedically-identified STD. The TAG should review and discuss the illness dictionary.

C. Explanatory Models of Sexually Transmitted Illnesses

One of the goals of the research will be to describe the explanatory model for each of the sexually transmitted illnesses with which the informants have experience. As previously discussed, each respondent will have his/her own explanatory model for an illness. The job of the social scientist will be to amalgamate the various responses and attempt to find commonalties among them to develop community-level explanatory models. These models might then be used in the STD Program to understand the patient/client perspective and to communicate more effectively with the patient population, both through the communication program and on a one-to-one basis by providers.

D. Answering the Programmatic Questions

The major component of the Final Report will be the summary of the data as it relates to the Programmatic Questions. Remember that one of the first tasks of the TAG was to identify local programmatic concerns and see how the data answers those questions.

It may be easiest to list all the questions, by topic, and to write the report in such a way that the text answers the question simply and in a

straightforward manner. The task of the TAG will be to combine the data from different Guides and to analyze it to answer a particular question. Chapter Six on analysis is written with this task in mind. The TAG should refer to Chapter Six to determine where to find the data and how to analyze it, in response to a particular question.

The answers to the Programmatic Questions will then naturally move to recommendations on how the data can be used in the STD Program. There may be some data which suggest that changes to the STD Program are not needed, while other data may direct the TAG to make specific recommendations about improvements to the Program. Chapter Eight on programmatic applications gives four concrete examples of how data may be used in components of the STD Program. Other examples might be improving logistics (drug supply), improving access (changes in the time the service are available), making structural changes (more clinics, more privacy in clinics), or improving the patient flow within clinics.

E. Preparing a Summary and Recommendations

From a practical point of view this is perhaps the most important part of the report because it represents a synthesis by the TAG of all the information gathered and because it is often the first and only section of the report that is read by the larger audience. This section provides an opportunity to clearly explain the relevance of the research and how it can guide future decisions regarding the STD program. In preparing this summary and recommendations the technical lead should consult with the TAG to ensure that they are appropriate, feasible and practical given the available resources. In the recommendations one should clearly indicate those recommendations based on the findings of the research as opposed to those that arise by some other means such as expert opinion or consensus of the TAG. The summary and recommendations section should be short and easy to read. A bullet format can make it easier to read. As a general rule it should be no more than two pages.

F. Appending Anonymous Interviews

An appendix to the Final Report should contain the actual typed interviews, making sure to remove all identifying information about respondents. Having the data as a part of the report enables other readers to use the data for their own purposes, or to look more closely at the data for specific information. An example of someone who would benefit from reading through the actual data would be the Communication Program Manager. She/he will be looking for language commonly used by community members to refer to these illnesses, to use in his/her STD Communication Program.

Programmatic Applications

A. Using the Data for Your Program

You may be wondering, after collecting and analyzing the data and writing the report, how you will be able to utilize the results to improve your STD Program. In the first section below, a few examples of results and their implications for programs are given as a demonstration of ways you can use the data to improve your program. In the second section, spin-offs, four types of strategic plans are described. These plans may be developed by TAG members who are experts in each area.

Using the programmatic questions outlined in Chapter One, a few examples can be given to show how results can be applied to the STD Program.

- ◆ Informants may believe that specific symptoms, for example, pain in urination, and discharge are indications of an illness, but that when these symptoms disappear (as they might with syphilis), that the illness has self-resolved. The result of this belief might be that informants wait to see if illnesses "self-resolve" before seeking health care. From this information you might decide that an objective of an improved program would be to encourage informants to seek care earlier in an illness episode. You might consider using this information to develop a set of communication materials about signs and symptoms to recognize for early and late stages of an illness.
- ◆ Informants may believe that certain illnesses such as syphilis and gonorrhea, can be treated by biomedical services, while others, such as vaginal discharge and itching, can only be treated by traditional healers. This information might lead to two separate but related programmatic changes. One would be to encourage women to seek care for vaginal itching and discharge from the biomedical services. Thus a communication strategy would be developed to reach informants

about the usefulness of biomedical treatment for this particular set of symptoms. Another strategy might be to work more closely with traditional healers, and to impress upon them the importance of referring cases of vaginal discharge and itching to the STD clinic.

- ◆ You might find that the informants' perceptions of quality of care available from STD services are quite low. Consumers might believe provider attitudes toward STD patients are negative, waiting time is long, privacy is limited or non-existent, supplies are inadequate, clinic hours are insufficient, and providers don't appear to know much about the treatment of STDs. From this information you might decide that an objective of an improved program would be to address these issues and improve the delivery and perceptions of quality at all service delivery sites. This would entail retraining of health providers to improve attitudes and communication skills, improvement of patient flow management (for example, requiring appointments rather than allowing walk-ins), upgrading of facilities to ensure privacy and adequacy of supplies, and a communication strategy to announce these changes to the public after they have been implemented.
- ◆ The data may show that women find it difficult to seek care from an STD clinic because of the stigma that is attached to care-seeking from such a facility. From this information you might decide that an objective of an improved program would be to include STD services in general maternal and child care, rather than requiring women to go to a specific STD clinic. This would entail a change in service delivery strategy, either relocating or retraining staff, and a communication strategy to announce the availability of new services within the comprehensive services available to women at their regular service delivery location.

B. Disseminating the Findings

While the information from this research will improve STD services to sex workers and their clients, an important activity in STD prevention and control efforts, the research should be cautious in the release of the information. The information is about socially marginalized groups and care must be taken that the release of the information should not cause adverse consequence such as raids on sex establishments. Persons

reporting the results should be careful to discuss sex workers as well as the clients of sex workers so that it does not send the implicit message that sex workers are "at fault" when it comes to transmission of an STD. The researchers should be prepared for interest in the information from media representatives and should think ahead about the kinds of question that might be asked about the findings and try and find responses that will diffuse sensationalistic types of coverage. TAG members can be used as spokespersons for the findings. TAG members can be

Figure 8-1. Ecological Levels of Determinants of STD

LEVEL	FACTORS	INTERVENTIONS
Intrapersonal ment,	development processes, knowledge, attitudes, values, skills, behavior, self-concept, self-efficacy and self-esteem	IEC strategies, skills develop- resistance to peer pressure
Interpersonal changing lies, social access to	social network, social support, partners, families, workgroups, peers, neighbors and health workers	changing social networks, group norms, enhancing fami- partner notification programs, support groups, increasing normative groups, and peer influence strategies
Organizational (health services and work-related clinics) ment,	norms, incentives, organizational culture, management styles, organizational structure, communication networks	organizational development, incentive programs, process consultation, coalition develop- linking agents
Community change ment	area economics, community resources, neighborhood organizations, community competencies, social and health services, organizational relationships, folk practices, governmental structures, formal and informal leadership	community participation, agents, community develop- and coalition empowerment, conflict strategies, mass media

given copies of the report and any other appropriate summaries of the findings. Whenever possible TAG members should be given copies of presentation materials (e.g. overheads or slides) so they may represent the findings on behalf of the research team. There may be other venues for disseminating the findings such as professional meetings.

It is important to find a way to disseminate the results to the respondents either directly or indirectly. One practical approach is to prepare a short summary of the findings and distribute this to organizations delivering services (may be clinical or social services like outreach education) to people in the setting of commercial sex. Sometimes there are opportunities to print this summary in a suitable newsletter or other type of information service.

C. Spin-offs

1. Developing a Model of the Problem

One of the first spin-offs to be produced is a "model" of the problem, as defined by the TAG. The problem is likely to be under-utilization of STD services. The factors that affect use exist on five different levels (McLeroy and Steckler, 1992) These levels are intrapersonal, interpersonal, community, organizational, and public policy. At each of these levels, determinants of use of STD services can be clearly spelled out. The data from this study should give you a clear understanding of the problems and probably some of the solutions related to these determinants. Figure 8-1 shows the different levels on which determinants exist, and gives examples of factors affecting STD service use and interventions that might be applied.

The model that you build will actually consist of a graphic description of how these determinants affect use of STD services. Once you have built the model, then you can begin to conceptualize where intervention would be useful, and the type of interventions that would be most effective. From that point, the next step would be to develop the STD Program Plan.

2. A STD Program Plan

Once you have understood the factors that affect the use and demand for the STD Program,

you will have some ideas about ways to improve it. The model that you have developed (see Figure 8-1) will show that different elements, such as individual knowledge and beliefs, social norms, prevalent perceptions about STDs, health service delivery issues, and public policies or laws, that affect the success of the Program. Different interventions will be appropriate to address each of these factors. The plan that pulls all of the interventions together is called a STD Program Plan.

The results of this research may demonstrate, for example, that community members do not have access to STD services. This is an organizational issue that impacts the placement of STD services, the days of the week or times of the day that services are offered, or may imply that outreach services are needed. It may also impact the communication about services which are currently available. Part of the problem relating to access may be perceptual, that is, the services are available but people don't know that they exist, or what days of the week or times of the day they are offered.

The STD Program Plan should include a cohesive statement of goals and objectives for all areas of the STD Program. It should include measurable objectives for the next year, and discussion about strategies to reach those objectives, as well as a plan for evaluating whether or not the objectives have been achieved. It should include a discussion of the persons and institutions responsible for implementing the plan, and how these different areas will be monitored and supervised.

3. A Communication Plan

The Communication Plan describes the strategic (not tactical) plans for a communication program on STDs. The plan identifies the primary and secondary target audiences for the communication program and gives a rationale for their selection. The plan describes the behaviors to be adopted by the primary target audience and the changes in knowledge, attitudes, and skills which will be required to support this behavioral change. In addition, the plan describes the supporting role played by the secondary target audience, listing its behavioral, knowledge and attitude requirements. The plan identifies possible constraints to adoption of these behav-

iors and skills, and to changes in knowledge and attitudes. It describes training needs, and the potential channels to be used in reaching target audiences. Finally, the communication plan describes the measurable program goals (outcomes) and the measurable objectives for the process and impact components of the program.

4. A Training Plan

The Training Plan describes the plans for training health workers involved in the treatment of STDs. The Plan identifies the major objectives of the training, and gives a rationale for how these objectives were defined. The Plan describes the knowledge, attitudes, behaviors, and skills to be taught. It describes the equipment, structural changes, and job aids required for the training. It discusses how this training will occur (for example, in one training session or in several shorter successive sessions) and includes a budget for implementation. It discusses resource needs (personnel, reference texts), as well as how and where these will be identified. The Plan includes a pre- and post-evaluation of the training and a daily schedule showing how the training will be implemented. Finally, the Plan will include the names or titles of those who will implement the Training Plan and how their responsibilities will be divided.

5. A Health Information System Plan

The Health Information System (HIS) Plan describes the information system that will be used to measure progress in treating STDs at the clinic. If there is no existing reporting system, one will have to be developed. If there is an existing system, the Plan will describe how the impact of the program activities will be measured through the HIS (what data, variables, what impact measures apply, etc.).

Clinical and Epidemiological Features of Four Common STD Syndromes



A. Urethral Discharge/Dysuria in Men

Urethral discharge and dysuria are two common symptoms of urethritis, an inflammation of the urethra by any cause. Itching at the end of the urethra is another common symptom. Urethritis is called gonococcal or gonorrhea, when *Neisseria gonorrhoeae* is detected and non-gonococcal urethritis (NGU) if *N. gonorrhoeae* cannot be detected. *Chlamydia trachomatis* is a common cause of non-gonococcal urethritis.

◆ *Neisseria gonorrhoeae*

N. gonorrhoeae is a gram negative bacterium. It initially infects mucosal epithelium of the genitals, rectum, pharynx and conjunctiva. It is transmitted almost exclusively sexually or perinatally and usually remains localized to the initial sites of inoculation although the infection can spread. It is the spreading of the infection that accounts for the most severe complications of untreated infections.

N. gonorrhoeae has been reported from all countries in the world. However, the prevalence of the disease in the population varies widely by region, age, sex and risk behavior. *N. gonorrhoeae* is usually transmitted by asymptomatic or minimally symptomatic infected individuals. The risk of a man acquiring gonorrhea from an infected woman is about 25%. The risk of transmission from an infected man to a woman is about 70%. The chance that a newborn becomes infected by passing through an infected birth canal is about 20%. The period of infectiousness of untreated or partially treated individuals is variable but may extend on for months.

In men, the most common clinical manifestation of gonorrhea is acute, anterior urethritis manifest by purulent discharge and dysuria. The incubation period ranges from one to 14 days

but the majority of cases have an incubation period of two to five days. Gonorrhea can also be asymptomatic or minimally symptomatic with an atypical appearance of scant or minimally purulent urethral exudate that is grossly indistinguishable from NGU. Untreated infections in men can cause infection of the epididymis which is manifest as acute pain and swelling of the testicle, urethral strictures and periurethral abscesses. Rarely, untreated gonococcal infections can disseminate and manifest as arthritis, dermatitis and tenosynovitis.

Men with urethritis are often treated presumptively for gonococcal and non-gonococcal urethritis simultaneously. Gonococcal urethritis in men can be diagnosed with urethral Gram stain. In men, a Gram stain of a urethral discharge is over 95 percent sensitive and specific. Gonorrhea can also be diagnosed with culture using special gonococcal media.

The treatment of gonococcal infections has been complicated in recent years by the almost worldwide resistance of the organism to common antibiotics including penicillins, tetracyclines and sulfa-based drugs. There is now widespread resistance to the fluoroquinolones reported in parts of Asia. In certain areas of the world aminocyclines and aminoglycosides are still effective. Additionally, the newer class of drugs, namely the cephalosporins are almost universally effective but more expensive. Most therapy for uncomplicated gonococcal infections is a single dose. However, because *Chlamydia trachomatis* is a common co-infecting pathogen which is not easily diagnosed (see below), co-therapy with an anti-chlamydial drug is also recommended. All sexual partners of the male index case in the previous four weeks should be referred and treated.

◆ *Chlamydia trachomatis*

C. trachomatis is a bacterium without a cell wall and an obligate intracellular parasite. It ini-

tially affects mucosal epithelium of the genitals, rectum, pharynx, conjunctiva and lungs. It is transmitted almost exclusively sexually and perinatally and usually remains localized to the initial sites of inoculation although the infection can spread. It is the spreading of the infection and the potential for infecting the newborn that account for the most severe complications of untreated infections.

C. trachomatis has been reported from all countries in the world. However, the prevalence of the disease in the population varies by region, age, sex, and risk behavior. It is a more common infection in many parts of the world than *N. gonorrhoeae*. Like gonorrhea it is usually transmitted by asymptomatic or minimally symptomatic infected individuals. The transmission dynamics of *C. trachomatis* are not well studied because of the difficulty in making an accurate diagnosis. However, it is known that the risk of a newborn becoming infected with *C. trachomatis* by passing through an infected birth canal is about 60 to 70 percent. The period of infectiousness of untreated or partially treated individuals is variable but may extend for many months.

In men, the most common clinical manifestation of chlamydial infection is acute, anterior urethritis. *C. trachomatis* urethral infection, however, is more often asymptomatic than gonococcal urethral infection, and when symptoms occur, they are milder with chlamydial urethritis. The incubation period ranges from 7 to 21 days. Untreated infections in men can cause infection of the epididymis which is manifest as acute pain and swelling of the testicle and prostatitis. Rarely, chlamydial infections in a genetically susceptible host can cause Reiter's syndrome characterized by conjunctivitis, arthritis and mucocutaneous lesions.

Men with urethritis are often treated presumptively for gonococcal and non-gonococcal urethritis simultaneously. Chlamydial infection is very difficult and expensive to diagnose. Most men treated for chlamydia are treated based on a urethral gram stain that shows signs of inflammation (polymorphonuclear leukocytes) and no evidence of gonorrhea. *C. trachomatis* can be definitively diagnosed using cell culture, antigen detection methods including fluorescent antibody and enzyme immunoassays, nucleic acid hybridization and amplification methodologies

like polymerase chain reaction and ligase chain reaction.

The treatment of uncomplicated chlamydial infections is usually accomplished with a seven day course of tetracycline, erythromycin or sulfa-based drugs, or a single dose course of Azithromycin. Failure to comply with prescribed therapy or re-exposure usually accounts for apparent relapse or failure of therapy. All sexual contacts of the male index case in the previous four weeks should be referred and treated presumptively.

B. Genital Ulceration

Genital ulcers, characterized by a defect in the epithelium of the skin or mucosa have several etiologies. The clinical presentation of genital ulcers is diverse, multiple infections are common and etiologic diagnoses are often impossible in most clinical settings. The management of genital ulcers is further complicated by the fact that classic presentations of the specific diseases are not always the rule, especially in the setting of HIV infection and self-treatment. Because of these difficulties, treatment recommendations for genital ulcer disease (GUD) are made based on syndrome and are directed towards the most common, treated etiologies in a specific area. The relative distribution of the causes of genital ulceration varies by region. However, the most important causes worldwide are syphilis, chancroid and herpes. Lymphogranuloma venereum and donovanosis also occur and are primary etiologies of GUD in certain areas of the world.

◆ Syphilis

Syphilis is caused by a bacterium called *Treponema pallidum*. It initially infects moist mucosal lesions and microabrasions. It is transmitted almost exclusively by sexual contact or in utero. It becomes a systemic disease shortly after its inception. It is the complications of untreated systemic spread of syphilis that account for most of the complications of the disease. Primary syphilis is manifest as an ulcer. All other stages of the disease, secondary, early latent, late latent, tertiary and neurosyphilis have different presenting signs or symptoms or

are asymptomatic and found by routine screening tests.

Syphilis has been reported from all countries of the world. The prevalence of positive syphilis serology varies widely by country. A few studies have evaluated the contribution of primary syphilis to genital ulcer disease. The rate of acquisition of syphilis from an infected partner has been estimated at about 30 percent. Transmission to the fetus in utero occurs for several years after the initial infection.

The clinical presentation of primary syphilis is an ulcer (chancre) at the site of initial inoculation. The incubation period ranges from about 10 to 90 days with an average of 21 days from exposure. The lesion is usually painless and associated with swelling in the regional lymph nodes. However, frequent exceptions to this classic appearance occur. Untreated, this primary chancre will heal in a few weeks.

The diagnosis of primary syphilis requires the demonstration of *T. pallidum* by dark field microscopy of a touch preparation of exudate from the lesion or by identification using fluorescent antibodies. In practice neither of these techniques is practical for most settings. Serologic tests provide only indirect evidence of primary syphilis. The VDRL, a non-treponemal screening test, is reactive in 50 to 70 percent of patients with primary syphilis. Because of these difficulties in diagnosing primary syphilis and the potential for severe sequelae, therapy of primary syphilis is recommended as part of the treatment in genital ulcer disease.

The treatment of choice for all stages of syphilis is intramuscular penicillin. For individuals that are hypersensitive tetracycline is recommended. All sexual partners of the index case for the previous three months should be referred and evaluated.

◆ Chancroid

Chancroid is caused by a gram negative bacterium called *Haemophilus ducreyi*. *H. ducreyi* is spread by sexual contact and occasionally by autoinoculation. Chancroid is much more common in men than in women. There appears to be no asymptomatic carrier state. Epidemiologically, chancroid is closely linked to prostitute contact. Chancroid is a major public health and medical

problem in many developing countries and often is the major etiology in genital ulcer disease. The major morbidity associated with chancroid is the local destruction of tissue and slow healing of untreated disease. Additionally, it is strongly linked to HIV transmission.

Clinically, the patient recognizes pain or tenderness of the ulceration or an associated inguinal node. In women, however, symptoms are dependent on the site of the ulcers; women can be asymptomatic or have complaints of pain on voiding, rectal bleeding or vaginal discharge. The incubation period is from three to ten days, most commonly four to seven days. Painful inguinal nodes are found in about half of the cases. These nodes can progress to become fluctuant bubos and can spontaneously rupture.

The diagnosis of chancroid depends on the isolation of *H. ducreyi* from a genital ulcer or bubo. Culture, however, is difficult in most settings because *H. ducreyi* is fastidious and requires specialized media. Direct microscopy has also been suggested but is misleading to the polymicrobial flora of most ulcers.

The treatment of chancroid has been complicated in recent years by the almost worldwide resistance of the organism to common antibiotics including penicillins, tetracyclines and sulfabase drugs and the increasing prevalence of HIV infection. The newer classes of drugs, namely the fluoroquinolones and the third generation cephalosporins are almost universally effective but in HIV-infected individuals more than a single dose may be necessary. A full five to seven day course of erythromycin also continues to be effective. Because of the difficulty in diagnosing chancroid, therapy for chancroid and syphilis is recommended in those areas where chancroid is common. All sexual partners of the male index case in the previous four weeks should be referred and examined. All identified ulcerations should be treated.

◆ Genital Herpes

Genital herpes is caused by infection with herpes simplex virus type two. Infections occur when there is contact on the mucosal surface or microulceration in the skin with virus from an individual who is shedding. With the initial infection the virus also ascends the peripheral nerves and

establishes a latent infection in the nerve root ganglia. Recurrent herpes lesions most often occur from reactivation of this latent infection. The major morbidity associated with herpes infection is the possibility of infection of a newborn and superinfection of primary infection.

Based on serology to herpes simplex virus type 2, antibody prevalence correlates with past sexual activity. Sex workers have higher antibody prevalence rates than patients in sexually transmitted disease clinics and individuals from the general population. Although few antibody studies have been done in developing countries, this pattern appears to hold. Transmission probably occurs during periods of asymptomatic virus shedding.

Clinically, the manifestations of herpes infection vary widely depending on whether the infection is the first episode of the disease or is recurrent disease. Primary infection is characterized by prolonged local and systemic symptoms. Pain, itching, dysuria, vaginal or urethral discharge and tender inguinal nodes are common local symptoms. Painful lesions, initially blisters which rupture and coalesce, are reported in the vast majority of patients. The mean time from the onset of symptoms to complete reepithelialization is about 20 days in primary infection. Median viral shedding occurs for 12 days from the onset of lesions. In contrast to the first episode of infection, recurrent infection is milder and shorter in duration with signs and symptoms localized to the genital region. The duration of a recurrent episode lasts about eight to 12 days with the average duration of virus shedding about four days after the onset of lesions.

The diagnosis of HSV can be made clinically if the patient presents early. Clinically one will see grouped vesicles on an erythematous base. Once the vesicles have ruptured and coalesced, one must use other diagnostic methods including demonstration of multinucleated giant cells on scrapings from the base of the ulcer (Tzanck preparation), identification of herpes antigen by enzyme immunoassay or fluorescent antibody, or by cell culture.

In most patients, except those that are immunosuppressed, genital herpes is a self-limited disease. Therapy, then, is used to shorten duration of the infection or to reduce the number of recurrences of the infection. Acyclovir, an acyclic nucle-

oside analog, is the mainstay of therapy in genital herpes infection.

◆ Lymphogranuloma venereum (LGV)

LGV is caused by one of three serovars of *Chlamydia trachomatis*. It is predominately transmitted sexually and rarely perinatally. The organism gains entry through disrupted epithelium. LGV is a chronic disease that has acute and chronic manifestations. The greatest morbidity of this disease is associated with the chronic sequelae of untreated disease including genital ulcers, fistulas, rectal strictures and genital elephantiasis.

LGV is a sporadic disease in North America, Europe, Australia and most of Asia and South America. It is endemic in Africa, India, parts of South America and the Caribbean. Acute LGV is reported more often in men than women probably because symptomatic infection is much less common in women. Late complications of the disease, however, are more common in women.

Clinically, the disease begins with a primary lesion, usually a papule, a shallow ulcer or small herpetiform lesion after an incubation period of about 12 days. It is often asymptomatic and inconspicuous, heals rapidly and leaves no scar. It can also cause a urethritis or cervicitis but the frequency of this manifestation is unknown. In the second stage of infection inflammation and swelling of the inguinal lymph nodes are the most common manifestations in men usually occurring ten to 30 days after initial infection. The lymph node enlarges and can become fluctuant. In women, lymph node swelling is less common. The second stage of the disease is associated with systemic spread of *Chlamydia*. The vast majority of patients recover from these stages without sequelae but in a few patients the persistence of *Chlamydia* in anogenital tissues incites a chronic inflammatory response leading to late complications.

The diagnosis is made by detecting antibody to LGV strains of *Chlamydia trachomatis* or by isolation of *Chlamydia* in tissue culture.

The recommended therapy of LGV is two to three week courses of tetracycline, erythromycin or sulfa-based drugs. Controlled trials of therapy have not been conducted.

◆ Donovanosis

Donovanosis is caused by a bacterium called *Calymmatobacterium granulomatis*. It is generally regarded to be sexually transmitted but the epidemiology of the disease is not completely defined. The major consequences of this disease are severe genital erosion and urethral occlusion caused by delays in seeking treatment. Donovanosis is rare in developed countries but is common in certain areas such as Papua New Guinea, India, Africa, and the Caribbean.

Clinically, the disease begins as single or multiple subcutaneous nodules which erode to produce clean, granulomatous, sharply defined lesions that are usually painless. These lesions slowly enlarge and bleed easily on contact. Fibrosis occurs with the growth of a lesion and edema and swelling are common.

The clinical presentation is highly suggestive of the diagnosis in most cases. The diagnosis can be definitely made with a stained crush preparation from the lesion. Donovan bodies, blue or black staining organisms with bipolar chromatin condensation, can be seen in mononuclear cells. Antibiotic choice is made based on local response. Therapy should be given until the lesions have completely healed (weeks). Chloramphenicol and gentamycin are the most effective drugs and cure the lesions in about three weeks. Other antibiotics that have been found useful include erythromycin, tetracycline and streptomycin.

C. Vaginal Discharge

The symptoms of vaginal discharge in women is a relatively non-specific complaint. It can represent a vaginal process or it can, less commonly, represent a cervical infection. It is not uncommon for women to have cervical and vaginal infections simultaneously.

◆ Cervicitis

Cervicitis is the female equivalent of urethritis in men although the symptoms of infection are less frequent and less distinctive than male urethritis. Clinical signs of cervicitis include cervical mucopus, increased cervical friability and increased numbers of inflammatory cells on Gram stain of cervical

exudate. The two major treatable causes of cervicitis are *N. gonorrhoeae* and *C. trachomatis*.

◆ *Neisseria gonorrhoeae*

For complete details on *N. gonorrhoeae* see the section on urethral discharge/dysuria in men above. In women the primary site of urogenital gonococcal infection is the endocervical canal. The most common symptoms in women are increased vaginal discharge, dysuria, intermenstrual uterine bleeding and menorrhagia. The incubation period appears to be more variable than in men but the median appears to be about ten days. The clinical assessment of women for gonorrhea is difficult because of the non-specificity of signs and the presence of frequent co-infections. Many women with gonorrhea have normal exams. Others, however, have cervical abnormalities that include purulent or mucopurulent cervical discharge, redness and swelling of the zone of ectopy, and cervical mucosal bleeding that is easily induced with a swab. Purulent exudate may be expressible from the urethra, peri-urethral glands or Bartholins duct. Untreated infection can ascend to the uterus and fallopian tubes causing pelvic inflammatory disease (see below). Rarely, untreated gonococcal infections can disseminate and manifest as arthritis, dermatitis and tenosynovitis.

Women with clinical cervicitis are often treated presumptively for gonococcal and non-gonococcal cervicitis simultaneously. Gonococcal cervicitis in women is more difficult to diagnose than gonococcal urethritis in men. A gram stain of a cervical discharge is only about 50 percent sensitive in detecting *N. gonorrhoeae*, although it is very specific. Gonorrhea can also be diagnosed with culture using special gonococcal media.

All sexual partners of the female index case in the previous four weeks should be referred and treated.

◆ *Chlamydia trachomatis*

For complete details on *C. trachomatis* see the section on urethral discharge/dysuria above. In women, the most common clinical manifestation of the chlamydial cervical infection is no signs or symptoms. About one-third of women with *C. trachomatis* cervical infection have local

signs including mucopurulent cervical discharge, edema, easily induced cervical bleeding, and increased numbers of inflammatory cells on Gram stain of cervical discharge. Like gonococcal infections, chlamydial infections in women can cause a urethritis and Bartholinitis. Untreated infection can ascend to the uterus and fallopian tubes causing pelvic inflammatory disease (see below).

Women with clinical cervicitis are often treated presumptively for gonococcal and non-gonococcal cervicitis simultaneously. Chlamydial infection is very difficult and expensive to diagnose. Chlamydia can be definitively diagnosed using cell culture, antigen detection methods including fluorescent antibody and enzyme immunoassays, nucleic acid hybridization and amplification methodologies such as polymerase chain reaction and ligase chain reaction.

All sexual contacts of the female index case in the previous 20 days should be referred and treated presumptively.

◆ Vaginitis

Infections, fungal overgrowth and bacterial disequilibrium can all cause the symptoms of abnormal vaginal discharge, abnormal vaginal odor or vaginal pruritis. It is these vaginal infections that account for the majority of symptoms in women. The most common causes of abnormal vaginal discharge include *Trichomonas vaginalis*, *Candida albicans* and bacterial vaginosis.

◆ *Trichomonas vaginalis*

Trichomonas vaginalis is a flagellated protozoan. The predominant cause of the human genitourinary trichomoniasis is sexual contact. There are no late complications to trichomoniasis known although some studies suggest that it, like most STDs, may increase susceptibility to HIV infection.

The prevalence of trichomoniasis in specific groups correlates with the general level of sexual activity. It is a very common infection in women. There is very little information on the prevalence of trichomoniasis in men.

Trichomonal infections in women are often accompanied by infections with other organisms; therefore, it is difficult to attribute symptoms

and signs observed to *T. vaginalis* alone. Nonetheless, malodorous vaginal discharge and vaginal pruritis are common complaints. About half of the women note some degree of dyspareunia or painful intercourse. On exam there may be erythema of the vulva or vagina. Rarely, punctuate submucosal hemorrhages may be seen. In men, the majority with trichomonal infection remain asymptomatic. It causes urethritis in a minority of patients.

The definitive diagnosis of trichomoniasis depends on demonstration of the organism either on wet mount (sensitivity of 40 to 80 percent) or Papanicolaou smear (sensitivity of 70 percent). The organism can also be cultured.

Most strains of *T. vaginalis* are highly susceptible to metronidazole. Asymptomatic male sexual partners of affected women should be treated.

◆ Vulvo-vaginal candidiasis

Candida albicans, a fungus, is commensal or a pathogen in the vagina. It is a change in the vaginal environment that induces the organism to become pathological. Predisposing factors to Vulvo-vaginal candidiasis include pregnancy, oral contraceptive use, diabetes and antibiotic use. Clinically, acute pruritis and vaginal discharge are the usual presenting complaints although the symptoms themselves are nonspecific. On exam there is usually erythema and a characteristic thick, cheesy discharge. The diagnosis is made with direct microscopy to identify yeast cells and mycelia after the application of potassium hydroxide solution to the slide. However, some symptomatic women will be missed with this test. Vulvo-vaginal candidiasis is treated topically with imidazoles or nystatin. Sexual partners are usually not treated in this disease.

◆ Bacterial vaginosis

Bacterial vaginosis (BV) is a very common cause of vaginal symptoms among women of childbearing age. It results from the replacement of the normal vaginal flora with a mixed flora. Bacterial vaginosis is associated with sexual activity but there is no clear evidence that it is sexually transmitted. BV may be a risk factor for pelvic inflammatory disease and may increase

Tables of Acronyms and References



A. Table of Acronymes

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
BV	Bacterial Vaginosis
FHI	Family Health International
GUD	Genital Ulcer Disease
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSV	Herpes Simplex Virus
IEC	Information, Education and Communication
LGV	Lymphogranuloma Venereum
NGO	Non-Governmental Organization
NGU	Nongonococcal Urethritis
PID	Pelvic Inflammatory Disease
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
RAP	Rapid Anthropological Procedures
FES	Focused Ethnographic Study
S W	Sex Worker
TAG	Technical Advisory Group
TIR	Targeted Intervention Research
VDRL	Venereal Disease Research Laboratories

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GUIDE ZERO

Introduction and Informed

0

I

Interviewer Instructions: The purpose of this Guide is to introduce yourself, help you to explain the purpose of the study, explain how the information will be used, and get an informant's agreement to participate. A second part of the Guide is a brief sociodemographic questionnaire to be administered with all individuals who agree to participate in the study.

Part A: Informed Consent

Statement: My name is _____. I am working with _____ to collect information on illnesses in the community and how they are treated so that health services here in _____ can be improved. All the information you give me will remain confidential and will not be associated with your name. The interview will last about one hour. Do you have time right now? I will be taking notes to remind myself of what you said. Do you agree to participate? Do you have any questions before we begin?

Note: This Guide should be administered at the start of each and every interview. Note that this statement should be modified as necessary to ensure that informants understand clearly what they are agreeing to and in a manner that reflects local norms with regard to obtaining informed consent.

Question Part B: Sociodemographic Background

Q

Interviewer: This part of the Guide should be given only once to each informant who agrees to participate in the study.

1. What is your name? (use initials or pseudonym) _____
2. How old are you? _____
3. How long have you lived in _____ (name of the town)?
4. What is your occupation? _____
5. How many children do you have? _____ What are their ages and gender?
6. How many people live in your house with you? _____ Who are they? _____
7. Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
8. What is your religion? _____

GUIDE ZERO

Introduction and Informed Consent, Continued

9. What ethnic group do you belong to? _____

10. What languages do you speak? _____ Read? _____ Write? _____

11. How many years of education have you completed?

Question 12. Do you own or have: radio, TV, car, bicycle, electricity, etc. (these and/or other relevant indicators of socioeconomic (SES) status)



To be completed by the interviewer:

Informant's gender: ☐ female ☐ male

Date of interview: _____

Language of interview: _____

Identifier notes: _____

Place (town) of interview: _____

Setting (clinic, bar, etc.) of interview: _____

For interviews with SWs: Briefly describe the interview setting and classify SES: low, medium, high

GUIDE ONE

Structure and Organization of Commercial

1

I

Interviewer Instructions: This Guide will enable you to get information about the different types of commercial sex in your community. The responses from this key informant interview will be used to decide which kinds of SWs and clients to interview for the majority of the interviews. There are three (3) steps to this interview, not including the introduction and informed consent statement you should have already administered.

STEP 1: Ask each question being sure to probe for in-depth information under each. Please be sure to indicate in your notes whether the key informant is basing their answer on personal experience with SW and clients, on their familiarity with research that has been done with SWs, or if their response represents their personal opinion.

STEP 2: At the end of the interview, ask the informant if s/he knows anyone else who could provide additional information. Also, ask the informant if s/he can help you to get access to the SW community for interviews at a later date.

You have concluded your interview. Ask the informant if they would like to add anything else. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE ONE

Structure and Organization of Commercial Sex

Questio



1. We consider sex workers to be people who have sex with someone in exchange for money, goods, drugs or alcohol. Please describe the different types of sex workers that you know about in _____ (name of community)? Are there both female and male sex workers?
2. Of all the types of SWs you just described, which have the greatest number of clients per day? Which groups of SW are least likely to be using condoms? Why do you think this is true?
3. Are there groups of SWs that rarely come into contact with cosmopolitan health services? Are there types of SWs that use services a lot?
2. What words do SWs use to label themselves and other individuals in the commercial sex environment? What are the different types of sexual partners that SWs have? What are the terms SWs use to describe these partners? What words do you suggest that we use to refer to sex workers and these different kinds of partners?
3. Can you describe the payment system for different types of SWs? Do SWs tend to have consistent contact with clients at a certain income level (probe for patterns)?
4. What is the economic relationship between SWs and other people in their environment? What are the financial obligations of different kinds of SWs, for example, obligations to pimps or brothel owners? What proportion of SWs do you think are financially supporting a household?
5. Where do SWs and clients meet each other? Where do they go to have sex? Do any of these locations have an effect on the kind of sexual behavior that occurs, for example, does the location make it more or less likely that the SW will use a condom or have riskier types of sex like anal sex? How does location affect other preventive action by either SWs or their clients (e.g. no light therefore cannot look for signs of STD in partner, no water supply therefore cannot wash genitals before or after intercourse)?
6. How do people first get involved in commercial sex? How do they learn about how the environment of prostitution functions (become "street-wise")? Do SWs "apprentice" before going out on their own?
7. Do all people who exchange sex for money, drugs, alcohol or goods consider themselves to be SWs? Are there some who do not think of themselves as selling sex? How do they describe themselves?
8. What are some of the characteristics of people who go into sex work? What kind of sexual history do they tend to have (eg. several different partners one after another, sexual abuse, etc.)?

GUIDE TWO

Illnesses Affecting the "Nether"

Interviewer Instructions: The administration of this Guide will enable you to get a free list of and learn about informant perceptions of illnesses affecting the "nether area." To avoid broaching this potentially sensitive topic too abruptly, the interview begins with a few general questions on adult illnesses (Questions #1–6) before transitioning to a focus on illnesses of the "nether area." Work with the other interviewers to arrive at a local expression which means "area between the waist and the knees," and make sure that all interviewers use the same expression when administering this Guide. If such an expression is either awkward or unclear, it may be helpful to use a picture to demonstrate the part of the body of interest or for the interviewer to demonstrate on her/his own body. There are nine (9) steps to this interview, not including the introduction and informed consent statement you should have already administered.

STEP 1: Ease into the questions on illnesses affecting the "nether area" by asking about adult illnesses generally (Questions (#1–6)).

STEP 2: Get a free list of names of illnesses affecting the "nether area" (Question #7).

STEP 3: For each of the "nether area" illnesses listed, beginning with the illness mentioned first, ask for a free list of the symptoms associated with the illness (Question #8).

STEP 4: After you get a complete list of symptoms for an illness, you must immediately ask for the order in which those symptoms appear.

STEP 5: Continuing with the same illness, you will ask several questions (Questions #9–17) about the characteristics of the illness regarding cause, prevention, treatment, and possible health complications.

STEP 6: For each illness mentioned, go through the same process (Steps 7–17, above).

STEP 7: After you have completed the questions for each of the illnesses you have been given, ask Question #18. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 8: If the informant answers affirmatively to Question #18, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 9: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE TWO

Illnesses Affecting the "Nether Area,"

Questio



1. Can you please list for me the most common illnesses which affect adults here in _____ (name of community)? [Be sure that respondents understand what is meant by "adult" by citing an age range or clarifying that you mean, for example, individuals old enough to have children. Politely stop the informant after she/he has cited around five illnesses. Select two or three of these and ask Questions #2–6.]

2. You told me that _____ (name of illness) is the name of an illness affecting the "nether area." Can you tell me the symptoms of _____ (name of illness)?

3. You just gave me a list of symptoms associate with _____

4. Does _____ (name of illness) affect women and men equally? If not, why
n o t ?
Does _____ (name of illness) also affect children?

5. How does one contract _____ (name of illness)?

6. Could you please describe the symptoms of _____ (name the illness)?

I want to now ask you some questions about illnesses in adults that affect the "nether area." [If necessary or helpful, demonstrate the area between the knees and the waist with a picture or on your own body.]

7. Can you please give me a list of the illnesses which affect the "nether area" here in _____ (name of community)? _____

8. You told me that _____ (name of illness) is the name of an illness affecting the "nether area." Can you tell me the symptoms of _____ (name of illness)?

9. You just gave me a list of symptoms associated with _____ (name of illness). Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

10. Can _____ (name of illness) be treated? If yes, how (i.e., traditional, biomedical, or popular remedies)? If no, why not?

11. How would you characterize _____ (name of illness)? Would you con-

GUIDE TWO

Illnesses Affecting the "Nether Area," Continued

sider it to be very serious, serious, or not so serious?

12. Can you tell me what is the cause or causes of _____ (name of illness)?
[Probe to ascertain if the informant distinguishes between the concept of ultimate cause and transmission.]

13. Are there certain people who cannot get this illness? If yes, why? [Probe women/men, young/older, etc.].

14. Can _____ (name of illness) cause infertility?

15. Are there any good things that happen if you have _____ (name of illness)?

16. Are there any bad things that happen if you have _____ (name of illness)?

17. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

18. Have you had any of the illnesses you mentioned that affect the "nether area"? If yes, which ones? If no, do you know anyone, such as a friend or family member, who has had any of these illnesses? Which ones?

[If the informant answers affirmatively to Question #18, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.]

GUIDE THREE

Illnesses Transmitted through Sexual

3

Interviewer Instructions: The administration of this Guide will enable you to get a free list of illnesses believed to be transmitted through sexual intercourse. Make sure to probe when discussing the “cause” of each illness, since an illness transmitted through sexual intercourse might be caused by some other agent. There are eight (8) steps to this interview, not including the introduction and informed consent statement you should have already administered.

STEP 1: Get a free list of names of illnesses the informant thinks are transmitted through sexual intercourse.

STEP 2: For each listed illness, beginning with the illness mentioned first, ask for a free list of the symptoms associated with the illness.

STEP 3: After you get a complete list of symptoms for an illness, you must immediately ask for the order in which those symptoms appear.

STEP 4: Continuing with the same illness, you will ask several questions (questions #4 - 11) about the characteristics of the illness, cause, prevention, treatment, whether it affects men and/or women, and its potential health consequences.

STEP 5: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 6: After you have completed the questions for each of the illnesses you have been given, ask Question #12. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 7: If the informant answers affirmatively to Question #12, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 8: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE THREE

Illnesses Transmitted through Sexual Intercourse,

Question



1. Can you please give me a list of the illnesses which are transmitted through sexual intercourse in _____ (name of community)?
2. You told me that _____ (name of illness) is the name of an illness that is transmitted through sexual intercourse. Can you tell me the symptoms of _____ (name of illness)?
3. You just gave me a list of symptoms associated with _____ (name of illness). Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)
4. Can _____ (name of illness) be treated? If yes, how (i.e., traditional, biomedical, or popular remedies)? If no, why not?
5. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?
6. Can you tell me what is the cause or causes of _____ (name of illness)? [Probe to ascertain if the informant distinguishes between the concept of ultimate cause and transmission.]
7. Are there certain people who cannot get this illness? If yes, why? [Probe men/women, young/old, etc.]
8. Can _____ (name of illness) cause infertility?
9. Are there any good things that happen if you have _____ (name of illness)?
10. Are there any bad things that happen if you have _____ (name of illness)?
11. Can _____ (name of illness) be prevented? If yes, how? If no, why not?
12. Have you had any of the illnesses you mentioned? If yes, which ones? If no, do you know anyone, such as a friend or family member, who has had any of these illnesses? Which ones? [If the informant answers affirmatively to Question #12, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.]

GUIDE FOUR

Illnesses with Specific Symptoms

4

I

Interviewer Instructions: The administration of Part A of this Guide will enable you to get five free lists of illnesses with specific symptoms. Part B of the Guide involves asking the informant a series of questions pertaining to the illnesses listed in Part A. You should have already obtained informed consent from the informant from Guide Zero.

STEP 1: Using the attached form, first ask if the respondent knows of any illnesses which have the symptoms listed on the form. Put a check mark next to the symptoms for which the respondent knows of illnesses.

STEP 2: Then complete the form on the last page of Part A, using the questions on the next page. Complete a free list of illness names associated with any of the symptoms selected.

STEP 3: Then move to the part of the Guide associated with the particular symptoms for which the respondent has already provided a free list (for example, if the respondent was able to provide a free list for illnesses associated with pain while urinating, administer Part B for each of these illnesses and referring to the symptom pain while urinating). For any illness which is mentioned in more than one free list, just ask the respondent to answer the questions for that illness once. The interviewer should then copy the information for that illness into other sections where applicable.

GUIDE FOUR, Part A: Illnesses with Specific Symptoms:

Free Lists for all Symptoms

Questio



I am going to read you a list of symptoms that are associated with different illnesses of adults here in _____ (community name). Can you tell me, as I mention the symptom, whether or not you know of any illnesses which are associated with the particular symptom?

2a. You have told me that you are familiar with illnesses which have the following symptoms (read from list). I would like to ask you some questions now about these symptoms.

2b. Can you please give me a list of the illnesses which have discharge from the vagina or penis as one of the symptoms?

2c. Can you please give me a list of the illnesses which have ulcers or open sores in the genital area as one of the symptoms?

2d. Can you please give me a list of the illnesses which have pain in the lower abdomen as one of the symptoms here?

2e. Can you please give me a list of the illnesses that cause pain when urinating as one of the symptoms here?

2f. Can you please give me a list of the illnesses that cause itching in the genital area as one of the symptoms here?

GUIDE FOUR, Part A

Data Collection Form for Free Lists of Illnesses with Specific Symptoms

NAME OF SYMPTOM	RESPONDENT KNOWS OF ILLNESSES WITH THIS SYMPTOM	NAMES OF ILLNESSES ASSOCIATED WITH THIS SYMPTOM
discharge from the vagina/penis		
ulcers or open sores in the genital area		
pain in the lower abdomen		
pain when urinating		
itching in the genital area		

GUIDE FOUR, Part B-F

Illnesses with Specific Symptoms:

discharge from the vagina/penis, ulcers or open sores in the genital area,
pain in the lower abdomen, pain while urinating, itching in

This Guide should be repeated for all of the illnesses cited by the informant for each of the symptoms listed above following the steps outlined below.

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free list of the other symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including alternately for each symptom listed above), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (Questions #3 -11) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #11. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #13, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B–F

Illnesses with Specific Symptoms: Continued



Interview: Please indicate the symptom used in this interview:

- ♦ Discharge from penis or vagina
- ♦ Ulcers or open sores in genital area
- ♦ Pain in the lower abdomen
- ♦ Pain while urinating
- ♦ Itching in the genital area

Question



1. You told me that _____ (name of illness) is the name of an illness that has _____ (cite one of the symptoms listed above) as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?
2. You just gave me a list of symptoms associated with _____ (name of illness), including _____ (cite one of the symptoms listed above). Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)
3. Can _____ (name of illness) be treated? If yes, how (i.e., traditional, biomedical, popular remedies?) If no, why not?
4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?
5. Can you tell me what is the cause or causes of _____ (name of illness)? [Probe to see if the informant distinguishes between the notion of cause and transmission.]
6. Are there certain people who cannot get this illness? If yes, why [Probe men/women, young/old, etc.]
7. Can _____ (name of illness) cause infertility?
8. Are there any good things that can happen if you have _____ (name of illness)?
9. Are there any bad things that can happen if you have _____ (name of illness)?
10. Can _____ (name of illness) be prevented? If yes, how? If no, why not?
11. Have you had any of the illnesses you mentioned? If yes, which ones? If no, do you know anyone, such as a friend or family member, who has had any of these illnesses? Which ones?

GUIDE FIVE

Core Illnesses

I Interviewer Instructions: For this Guide, you should be using the list of Core Illnesses which was generated from the results of the interviews from Guides Two through Four. You should also be administering this Guide to “key informants” - respondents who you have interviewed previously and who have told you that they have personally experienced one or more of the illnesses under consideration or that they know someone who has. Prior experience implementing the TIR suggests that giving informants the “option” of talking about their own experiences as those of someone else may be important for some individuals to speak comfortably and openly. There are thus two options of this Guide, one to be used with informants who report having experienced and an STI-related infection personally and one, only slightly different from the first, to be used with persons who claim to know about the experiences of someone else who has had an STI-related illness.

Part A: Personal anecdotes about core illnesses: (Option for informants who report personally having experienced STD-related illness)

Q In a previous interview, you told me that you have had _____ (name of illness). Could you tell me a few things about that experience?

1. The name of the illness is _____.
2. What symptoms did you notice first?
3. Did you seek treatment? (If yes, go to Question 5. If no, go to Question 4.)
4. Why did you decide not to try to find treatment?
5. What motivated you to try to find treatment (i.e. discomfort/pain, effect on “business”, fear of transmission to others)?
6. How long did you wait before trying to find treatment?
7. What do you think caused this illness?
8. When you went for care, were you told about having sexual intercourse during treatment? What were you told?
9. Did you continue having sexual intercourse before seeking treatment? If not, why not? If sexual activity was continued, why?
10. IS THERE A QUESTION 10?

GUIDE FIVE, Continued

Core Illnesses

12. If treatment was sought, where did you look for treatment first? (probe for precision on treatment choice: biomedical clinic, home remedy, self-medication with pharmaceutical, traditional healer, etc.) Why did you go to _____ (site of care mentioned) and not to another place first?

13. How did you go about deciding where to go to get treatment (i.e. choices available, attributes of different treatment options, advice from anyone)? Why would you not go to _____ (site of care not mentioned by informant)?

14. Who else did you consult about on where or where not to get treatment? Who helped you decide where to try to get treatment (probe for advice from friends, bar/brothel/establishment owner, pimp, madame, etc.)?

15. At the _____(site of care mentioned by informant), what exactly did you tell them? Did you include ideas about how you got this illness? Did you mention specific symptoms? If so, which ones? How did you feel about talking about your illness with the _____ (type of provider) (i.e. easy or difficult to discuss and why; embarrassment)?

16. What were you told about treatment and prevention for the future at the health center/traditional healer/drug vendor?

17. How did the (health worker, traditional healer, pharmaceutical vendor) talk to you? Were they sympathetic or scolding?

18. Who else (besides a health worker) did you tell about symptoms? Any other SW you work with? Anyone else in the place where you work? Any relatives? Husbands, girlfriends, boyfriends, wives? (Probe for who was told and who was not told and why?) What did you tell these people about the illness?

19. Did you feel like people's attitudes towards you were affected by knowing that you had this illness? Are there different kinds of people that you can tell about this illness and other kinds of people that you cannot? Why can't you tell some types of people about this illness? (i.e. is there a stigma attached to having this illness?)

20. Have you done anything to prevent your getting this illness again? If yes, what have you done? If no, why not? (Probe for prophylactic antibiotic use, lack of information, empowerment issues, access)

21. Did you try to get any treatment for any of your partner(s)? If so, what kind of partner(s) (regular client, boyfriend, spouse, etc)? If not, why not?

22. If someone like you was unable to have children, how would that affect their life?

GUIDE FIVE

Core Illnesses

5



Part A: Personal anecdotes about core illnesses (Option for informants who report knowing someone who has experienced STD-related illness)

Question



In a previous interview, you told me that you know someone (e.g., a friend or relative) who has had _____ (name of illness). Could you tell me a few things about that experience?

1. The name of the illness is _____.
2. What relation are you to the person who had _____? Why do you think she/he told you about it? Did you help the person in any way or give her/him advice on what to do? Explain how you helped.
3. What did she/he tell about her/his illness? How did she/he describe the symptoms and when they were first noticed?
4. Did your friend/relative seek treatment? If yes, go to Question 6. If no, go to Question 5.
5. Why did you think she/he decided not to try to find treatment?
6. What motivated your friend/relative to try to find treatment (i.e. discomfort/pain, affect on "business", fear of transmission to others)?
7. Do you know how long she/he waited before trying to find treatment? Why did she/he wait?
8. What do you think caused this illness?
9. How do you think this illness was transmitted to your friend/relative?
10. Do you know what your friend/relative was told about having sexual intercourse during treatment?
11. Did she/he continue having sexual intercourse before seeking treatment? If not, why not? If sexual activity was continued, why?
12. Did her/his behavior change as a result of having this illness (i.e., did you use condoms, did you avoid a person or category of persons)? If yes, how so?
13. If treatment was sought, where did your friend/relative look for treatment first? (probe for dif-

GUIDE FIVE

Core Illnesses, continued

14. How did she/he decide where to go to get treatment (i.e. choices available, attributes of different treatment options, advice from anyone)? Why wouldn't she/he go to _____ (site of care not mentioned by informant)?

15. Do you know who else did your friend/relative consult about where or where not to get treatment? Who helped her/him decide where to try to get treatment other than yourself (probe for advice from friends, bar/brothel/establishment owner, pimp, madame, etc.)?

16. What was your friend or relative told about treatment and prevention for the future at the health center/traditional healer/drug vendor?

17. How was she/he talked to by the health worker/traditional healer/drug vendor? Were they sympathetic or scolding?

18. Did you feel like people's attitudes towards your friend or relative were affected by knowing that she/he had this illness? Are there different kinds of people that one can tell about this illness and other kinds of people that one cannot tell? Why? (i.e. is there a stigma attached to having this illness?)

19. Do you think that your friend/relative has done anything to prevent getting this illness again? If yes, what? If no, why not? (Probe for prophylactic antibiotic use, lack of information, empowerment issues, access)

20. Did she/he try to get any treatment for any of your partner(s)? If so, what kind of partner(s) (regular client, boyfriend, spouse, etc)? If not, why not?

21. If your friend/relative were unable to have children, how would that affect their life?

GUIDE FIVE, Part B:

Basic questions about core illness-



Interviewer Instructions: If there are illnesses for which no "key informant" was identified, you may alternatively seek out new informants to find answers to these questions. Using the list of core illnesses generated from Guides Two through Four, ask the following list of questions for each of the illnesses for which you have no information.

Questions



In a previous interview I was given a list of illnesses that adults here suffer from. (Read from core illness list.) Can you help me by giving me some more information about any of these illnesses?

1. Have you heard about _____ (name of illness)?
2. How did you learn about _____ (name of illness)?
3. Who can get _____ (name of illness)?
4. What is the cause or causes of _____ (name of illness)? (Probe for both biological and spiritual/witchcraft causes)
5. Is _____ (name of illness) a severe illness? If yes, why? If no, why not?
6. What are the symptoms of _____ (name of illness)?
7. In what order do these symptoms appear? After how long does _____ (name each symptom) appear?
8. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?
9. When does a person get _____ (name of illness)?
10. Why does a person get _____ (name of illness)?
11. Who can treat _____ (name of illness)? (Probe for traditional, biomedical, pharmaceutical vendors, and other health resources.)
12. How can _____ (name of illness) be treated? (Probe for traditional, biomedical, home, and other popular sector remedies.)
13. Is the treatment to relieve the symptoms or can _____ (name of illness) be cured? If so, by whom? How can _____ (name of illness) be cured?

GUIDE FIVE, Part B:

Basic questions about core illnesses, continued

15. Can a person transmit _____ (name of illness) to someone else? If so, how?
16. Are there consequences of not treating the symptoms of _____ (name of illness)? If yes, what are they?
17. Are there consequences of not curing _____ (name of illness)? If yes, what are they?
18. Does _____ (name of illness) go away by itself? In what situation does it go away (i.e. how long)?
19. When a person has _____ (name of illness), who else can be affected? (for example, children, wives, husbands, girlfriends, boyfriends)
20. Is _____ (name of illness) common here?
21. Is _____ (name of illness) appropriately treated only by certain health resources? Why would a person not go to seek help from other sources of care?

GUIDE SIX

Sex Worker Client Intercept and Interview

Interviewer Instructions: There are three (3) parts to this Guide. The first part is called an intercept interview designed to be used in a situation where clients of SWs can be easily identified (bar, brothel, or clearly associated with street-based SWs). It is assumed that clients will not feel they have much time available to respond to many questions therefore the guide has only a few questions and is designed to take about 20 minutes to complete. For the intercept interview, it is important to assess whether or not the client can answer questions truthfully (eg. others can hear his responses, is he intoxicated, etc.). The second and third parts of the Guide can be used with a client who agrees to be interviewed for up to 1 1/2 hours in a location removed from the commercial sex environment. The second part is an in-depth interview and the third part of the Guide is a brief questionnaire that may be administered as well. Make sure to administer Guide Zero (informed consent) before beginning either the intercept or the in-depth interview and questionnaire.

Questionnaire Part A: Client Intercept

Q

1. Have you ever had an illnesses that you got from having sexual intercourse with someone? If so, please think of the last time you had one. For this last illness you had, did you seek treatment? Where did you get treatment? How can you tell if the treatment cured your illness? How would you describe any pain or discomfort that this illness caused you?
2. If you never have had one of these illnesses, what do you think you would do if you had one and wanted to get it cured?
3. Do you know what this is (show wrapped condom)? What have you heard about condoms? Is it the customer or the SW who prefers not to use condoms? Why?
4. What are the clinics you know of that offer services for these illnesses? What is your opinion of these clinics (eg. problems with confidentiality, location, cost, perceived quality of care, etc.)?
5. Where can you go to get drugs that can cure these illnesses? Is it difficult to get these drugs?

GUIDE SIX

Part B: Client In-depth Interview



Interviewer Instructions: If the informant for this interview has already been asked all of the intercept questions in part A of this Guide, you can skip questions number 4, 5 and 8.

Questions



1. Can you please tell me the illnesses you know of which people can get from having sexual intercourse? How can you tell if someone has this illness (probe for symptoms)?
2. What are the ways you can avoid getting these illnesses (probe for types of people likely to be infected, riskier behaviors like anal sex, hygiene, looking for overt symptoms of STD in SW or client)?
3. Have you ever had any of these illnesses? Which ones have you had?
4. If you have had one of these illnesses, please think about the last time you had one. For this last illness you had, did you seek treatment? Where did you get treatment? How can you tell if the treatment cured your illness? How would you describe any pain or discomfort that this illness caused you?
5. Are there any other things you did while you had this illness (probe attitudes towards abstinence with SW or with other steady partner/s)?
6. If you never have had one of these illnesses, what do you think you would do if you had one and wanted to get it cured?
7. If one of the SW you had been with was sick with an STD, would you want to be told? If so, why and who would you want to tell you (health care worker, bar/brothel owner, SW themselves)? If not, why not?
8. Do you ever talk with the SW about how to avoid getting these illnesses (probe for talk about condom use and self-medication)?
9. Do you know what this is (show wrapped condom)? What name do you use for it? Where can you get them? Do you ever carry them with you? How about when you go to a SW?
10. What do you think about how it is to use a condom when you are with a SW (difficult, easy, etc)? Do you think customers and SWs usually want to use condoms? Do some customers or SW prefer not to use condoms? Why do you think they don't want to use condoms?

GUIDE SIX

Part B: Client In-depth Interview

11. What are the clinics you can go to if you have one of these illnesses? What is your opinion of these clinics (eg. problems with confidentiality, location, cost, perceived quality of care, etc.)? What would you like to see change so that you would be more interested in going to a clinic when you had an STD?

12. Are there other types of people who can examine you for these illnesses (eg. pharmacist, traditional healer, alternative practitioner, etc.)? Can they give you a treatment to cure the illness (probe for why better and under what circumstances is better to go to these practitioners)?

13. Do you ever take any treatment to prevent one of these illnesses by yourself (self-treatment: home remedies, buy at pharmacy by drug name, etc.)?

14. Where can you go to get drugs that can cure these illnesses? How easy or difficult is it to get these drugs? Why (probe for cost, availability, etc.)?

GUIDE SIX

Part C: SW Client Brief

Sex ☐ Male ☐ Female

How old are you? _____

How many years of education do you have? _____

In the last month, how many times have you had sexual intercourse? _____

In the last month, how many times have you had sexual intercourse with a SW?

The last time you were with a SW, how much did you pay to have intercourse with them (including the cost of drinks and entrance to an establishment)? _____

The last time you were with a SW, did you use a condom? _____

How old were you when you first went to a SW (approximate age at first sexual contact with SW)?

Have you ever had an STD? _____ If yes, please think about the last time you had an STD. _____

Were you examined by a medical person? _____

Where did you go for this exam? _____STD clinic
 _____Hospital
 _____Family Planning Clinic
 _____Private doctor
 _____Other: _____

Where did you go to get treatment? _____Clinic only
 _____Clinic and pharmacy
 _____Pharmacy only
 _____Traditional healer
 _____Didn't go for treatment
 _____Other: _____

What treatment did you get? _____

Drug name _____ dose# _____ days _____ cost

GUIDE SIX

Part C: SW Client Brief Questionnaire, Continued

How likely do you think it is that you will get an STD in the future? _____

How likely do you think it is that you will get infected with the AIDS virus in the future?

Where are the places in your community where you can get condoms?

- _____ Clinic
- _____ Pharmacy
- _____ From CSWs
- _____ In the bar/brothel but not from CSW
- _____ Other: _____

Where do you usually go to find SWs?

- _____ Bar
- _____ Hotel
- _____ Brothel
- _____ On the street: _____
(specify street or neighborhood)

GUIDE SEVEN

Interview with Brothel Owners, Administrators, etc.



Interviewer Instructions: This Guide is designed to take about 1 hour to complete. Make sure to administer Guide Zero (informed consent) before beginning each interview.

Questions



1. What is your relationship with sex workers (i.e., role vis-à-vis sex workers)? How do you identify new SWs to work for/with you?
2. What is the biggest problem you have in your business? What do you do to try to control this problem?
3. Can you please tell me about the illnesses you can get from having sexual intercourse with someone?
4. Have you ever had one of these illnesses? If yes, what did you do and why? Have you ever given advice to others with these illnesses? Who did you give advice to, what advice did you give and why?
5. What happens when a SW has an STD (eg. support for health-seeking behavior or obstacles)?
6. Does it affect you or your business when a client has an STD (eg. reputation as commercial sex establishment)? Is it possible to tell clients when a SW has an STD so that they can get treatment as well? If so, who can tell them? If not, why not?
7. Do you know of any clinics where SWs or clients can go for treatment of these illnesses? What is your opinion of the treatment available there (eg. satisfaction or no with the diagnosis, drugs available, cost, communication with the provider, etc.)?
8. Do you ever talk with any doctors or nurses about these illnesses people get in your business (eg. refer SWs to services regularly, constructive relationship with clinic staff, avoids contact with health providers)? Why or why not?
9. Would you be interested in helping the clinics to keep the SWs healthy? If so, how do you think you could help?
10. Are there ways to prevent these illnesses one can get from having sexual intercourse?
11. What is your opinion of condoms (probe for obstacles to use: cost, availability, believe ineffective

GUIDE EIGHT

Guide for Health Workers and Pharmacists

Part A: List of local language names for illnesses and symptoms transmitted through sexual intercourse

I

Interviewer Instructions: Get a list of terms in the local language for illnesses and symptoms that correspond to biomedically-defined STDs.

Question

Q

1. Which one of the STDs or syndromes listed here or others you can think of are the most common ones you see?

2. Which ones do you think are the most important? Why are they important?

3. Can you please tell me the local language names that you are aware of for the following illnesses and symptoms listed?

1. Syphilis
2. Gonorrhea
3. Warts
4. Ulcers
5. Bubo
6. HIV or AIDS
7. Vaginal discharge (vaginitis)
8. Vaginal itching (vaginitis)
9. Discharge from penis
10. "STDs"
11. Edema

GUIDE EIGHT, Part B:

Other Health Worker Questions

1. Of all the people you see who have an STD, what proportion do you think got it from having sex in exchange for money or gifts?

I would like you to please think about these types of patients when you answer all of the following questions

2. What questions do you ask patients suffering from sexually transmitted illnesses (probe for cause, transmission, sexual behavior, treatment, partner notification)?

3. Other than giving them a prescription, what do you tell patients suffering from sexually transmitted illnesses (probe for cause, transmission, sexual behavior, treatment, partner notification)?

4. How do you feel about your ability to talk about sexually transmitted illnesses with your patients? Is it difficult? Comfortable?

5. How do you think patients suffering from sexually transmitted illnesses feel about talking about their illness? How is a patient with a sexually transmitted illness different (in terms of disclosure, advice taking, partner notification) than patients with other illnesses?

6. What could make it easier for you to talk with patients about sexually transmitted illnesses?

7. What kinds of differences are there between men and women related to sexually transmitted illnesses (probe for inapparent illness, symptoms, terminology, effects, stigma, partner notification and referral for treatment, treatment, prevention)? Among these people, is there a group of people who are more important to give treatment for an STD than others? If so, why?

9. Are there a lot of STDs in this country/region? If yes, why? If no, why not?

10. What are the most important problems you face in trying to provide adequate STD services for your community (eg. availability of drugs, cost of drugs to the patient, cost of diagnostic tests, staff have too many responsibilities or too little time to give care, staff do not know how to communicate with the patients)?

11. You have just told me about all the problems you face in trying to provide STD care to SWs and their clients. What is your opinion about giving care/treatment to these kinds of people (probe for comfort level dealing with SW or with male clients; probe for attitude towards these types of people – i.e. are sex workers seen as “bad people”)?

12. When giving care/treatment to these people, what are the most important health problems that should be addressed first? Why?

GUIDE NINE

Clinic Questionnaire



Interviewer Instructions: There are three parts to the clinic Guide. Part A, which is intended to establish treatment seeking trajectories of patients, may best be administered to patients during the waiting time between registration and the actual visit. The process of selecting patients to participate in the study will depend on local circumstances, for example, if the clinic site is an STD clinic or a primary health clinic that treats STDs along with other illnesses. Part B of the Guide should be filled out by the provider during the visit. The research team should work closely with clinic personnel to modify this process as necessary in order to accommodate clinicians' busy schedules and heavy workloads; if, for example, a clinic procedure is already in place where most of this information can be derived, this Guide should be modified so as to avoid asking clinicians to repeat work. Part C should be administered after the patient has seen the provider and has received information on diagnosis, treatment and follow-up. Make sure to administer Guide Zero (informed consent) before enrolling the patient in the study.

Part A: Clinic Entrance Questionnaire for Patients Visiting an STD Clinic Questionnaire



I would like to ask you some questions about your visit here today while you are waiting to be seen by the health provider. Is that ok?

Patient ID #: _____

1. Can you tell me why you are here today? (probe for clinical history, symptoms, cause, transmission)
2. When did the problem first begin?
3. Did you ever think this was another problem (i.e., a different illness)?
4. Name all the illnesses you thought this was.
5. When you first noticed symptoms, did you talk to any one about them (i.e., a lay advisor such as a friend or family member)? What did she/he advise you to do? Did you follow her/his advice? If yes, why? If no, why not?
6. What did you do first to try to get rid of the illness (e.g., go to a practitioner [biomedical, traditional, informal sector]; go to a pharmacist or other drug vendor; self-medicate with a home, traditional, or pharmaceutical remedy)?

[Interviewer: If coming to this clinic was the patient's first resort to therapy, skip to Question #10.]

7. Did this help? If yes, did symptoms come back? If no, did the symptoms get change or worsen?
8. At this point, did you talk to any one about your illness (i.e., the same lay advisor, any one else)? Who? What was her/his advice?

GUIDE NINE

Clinic Questionnaire, Continued

9. Then what did you do (e.g., go to a practitioner [biomedical, tradition, informal sector]; go to a pharmacist or other drug vendor; self-medicate with a home, traditional, or pharmaceutical remedy)?

[Interviewer: Repeat Questions #7 - 9 for each action taken in the care seeking process identified by informants. It is important to probe for full description so that complete and detailed treatment seeking processes of patients may be reconstructed in later analysis.]

10. Why did you [finally] decide to come to this clinic?

11. Have you been having sexual intercourse since you have had symptoms? If no, when did you stop? Why did you stop? If yes, why are you continuing?

12. Is your sexual partner also seeking treatment? If no, will you ask your partner to seek treatment? What is your relationship with this person (regular clients, boyfriend, spouse, pimp, etc)?

[Interviewer: Ask the informant if she/he would agree to another interview after seeing the clinician and make arrangements accordingly.]

GUIDE NINE, Part B:

Provider Form for Clinic Questionnaire

Patient ID #: _____

This guide can be used as either an open-ended questionnaire to be completed by the provider or as an observation conducted by the field interviewer during a clinic visit.

Provider: Please fill in the following information on the patient who has handed you this form, after you have completed the visit. If there are other people in your clinic who have had contact with the patient, (i.e. nurse, social worker, etc.) you may choose to have them complete or add information to this form.

Observer: Please indicate your notes on this sheet.

1. Diagnosis:

2. Information asked of patient:

3. Information given to patient:

4. Treatment prescribed? Yes/No. If yes, what was prescribed?

5. What other advice was given (i.e., sexual behavior, prevention)

6. Will partner(s) be notified? If yes, by whom? If not, why not?

7. Give out condoms? How many?

8. Other follow-up required?

GUIDE NINE, Part C:

Exit Interview with Patients

Patient ID #: _____

1. What is the reason for your clinic visit today?
2. What did the provider ask you to tell him/her (probe for cause, transmission, symptoms, partner issues)?
3. What did the provider tell you (probe for cause, treatment, prevention, sexual behavior, partner notification)?
4. How did you feel about the conversation you had with the provider?
5. How did you feel about the way the provider treated you?
6. How did you feel about the provider's knowledge on the subject?
7. How did you feel about your own ability to talk with the provider?
8. How do you feel about the way the other people in the clinic treated you?
9. Do you have any additional questions that you would like to have the opportunity to ask before leaving?
10. How did you feel about the overall visit (probe for waiting time, cost, provider attitudes, adequate supplies, privacy, authority of service)? If you could change any of these things, what is the most important thing to change?
11. Would you advise your friends to come to this clinic for help if they had a similar problem? If so, why? If not, why not?

GUIDE TEN

Sexual Practices, Condom Use and Other Preventive Behaviors

Part A: Client Recruitment

Interviewer Instructions: For this Guide, you should be familiar with the local terminology used to name condoms and STDs generically. You should bring a few small props including, one wrapped condom for each interview and one model of a penis, to be used in testing SW condom use skills. You should be administering this Guide to a “key informant.” The questions in this interview ask the informant to describe his/her sexual practices, condom use and other preventive behaviors.

1. How is business these days? [Interviewer try to find out if it has changed over time.]
2. How long have you been in this business?
3. Where do you meet prospective clients? How do you meet clients? Where do you go with clients to have sex?
4. How many clients do you have on a typical day? On a very busy day? How many days per week do you work?
5. What is the usual compensation (money and/or in kind)? Who set the price? Has the price changed? [Interviewers probe to see if price is strictly money or in kind.]
6. What services do you usually offer? [Interviewer, please focus on penetrative vaginal and anal intercourse.] Are there any other services you do occasionally? Are there any differences in the prices for these services?
7. Are there different kinds of clients? Why are they different (i.e. different price, different type of sex—oral, vaginal, anal etc.)?
8. Do some clients ask for services that are different than the usual ones? Is there a word you use to describe SWs who do these services? Can you please describe these services?
9. Are there some requests that you refuse? Which requests? Are there circumstances when you will have anal sex (his penis in your anus) with a client (i.e. with regular client, for more money, etc)?
10. Are there ways to avoid getting an STD from your clients? If yes, what are these ways (probe for which ones thinks are more effective)?
11. Do you work while you are having your period? Is there anything different that you do at this time?
12. Have you ever been pregnant? Do you work throughout your pregnancy or are there times when you do not work?

GUIDE TEN

Sexual Practices, Condom Use and Other Preventive Behaviors, Continued

Part B: Client Screening/Hygiene

14. Do you check your clients for any signs or symptoms of STDs?

—if yes, how do you check them? (i.e. look for skin abnormalities, look for swelling, squeeze penis for discharge, squeeze/touch for scrotal tenderness)

—if yes, what signs and symptoms do you look for? What illnesses might these be?

—if yes, do you check all your clients? [interviewers, probe—some clients only]

—if yes, have you ever found a client who was infected with an STD? What STD did they have? Did you have sex with him? If yes, did you do anything to keep yourself from catching the illness? Did you say anything to him about STDs? Did you talk with him about how to treat STDs?

15. If you do not check your clients for any signs or symptoms of STD, why not?

16. Do you ask clients to perform any hygiene before starting sex? If so, what? If not, why not? [Probe for barriers, e.g., no water.]

Part C: SW Screening/Prevention/Hygiene

17. Speaking of checking for STDs, do you examine yourself for signs and symptoms of STDs? How do you examine yourself? What do you look for?

18. Do you go anywhere on a regular basis to be checked for STDs?

19. In general, what do you do to prevent getting STDs? [Interviewer, probe for biomedical, traditional, and other methods.]

20. Do you ever take pills or injections to treat/prevent STDs? What kind of pills/injections? Where do you go to get these? Do you treat yourself or does someone treat you?

21. Have you ever had an STD? Which one? What were the signs and symptoms you recognized?

22. Do you do anything to clean yourself either before or after being with a client? If so, what do you use? When do you do this (i.e. after each ejaculation, at end of evening before go home) and why do you think this is a good thing to do?

23. If you don't clean yourself either before or after being with clients, how often do you wash your genital area with soap and water? Do you ever give yourself a vaginal douche or put anything else inside your vagina? Would you like to do anything different to keep yourself clean?

GUIDE TEN

Sexual Practices, Condom Use and Other Preventive Behaviors, Continued

GUIDE TEN

Sexual Practices, Condom Use and Other Preventive

34. Would you show me how to put a _____ (condom) on this model, pretending it is a real penis?

[Interviewer, if the informant agrees run through the condom use simulation, mark those steps informant used.]

- | | |
|------------------------------------|--------|
| a. successfully opened packet | yes/no |
| b. no fingernails & no teeth | OK/no |
| b. squeezed air out of top | yes/no |
| c. unrolled condom without tearing | yes/no |
| d. mention take off while erect | yes/no |
| e. knot at end before dispose | yes/no |

35. What do you do with the _____ (condom) after it has been used? (Disposal, reuse etc).

36. Where do you get _____ (condoms)? From what other places are condoms available? Why don't you get your supply there?

37. Do you have any condoms on hand? May I see one? [Interviewer, note brand, condition, number on hand.]

GUIDE ELEVEN

Service Delivery

11



Interviewer Instructions: In this interview you will ask the SW about her/his experience with health services. It is assumed that you will be asking these questions of “key informants” who are SWs and have been identified through previous interviews. Even though some of the questions are specifically about their last illness episode, the informant will probably use all his/her experience with health services to be able to answer.

Question



Today I am interested in talking with you about where people go for treatment when they have STDs. Would you mind telling me about this?

Part A: General questions

1. Where do people like you go when they have an STD and they want to go to a doctor or nurse to identify the illness they have and get advice about how to cure the STD (separate STD clinic, comprehensive clinic like family planning, maternal and child health or general medicine, other)?
2. Are there some types of health centers that are better for STDs than others? If yes, why?
3. Have you ever had an STD? Please think about the last time you had an STD (prompt for name some symptoms or illness names if necessary). Did you seek treatment from a clinic? If yes, where did you go? Why did you choose this clinic (probe for appraising features of health services as well as barriers)?
4. Is there any regular STD testing program that you or people like you participate in? Is it required or optional (if required, go to Part B)?
5. Are there ways to make it so that the clinic will not “find” an STD when they examine you? (probe for prophylactic behavior—antibiotic use, douching and/or internal vaginal cleansing) When do you do this (i.e. how close to clinic visit)?
6. How much did you have to spend to get services at the clinic (medical exam and consultation, drugs, transportation, other costs)? How much can you afford to spend in order to get treatment for an STD? Is this price worth the treatment? Would you pay more?
7. How did you travel (foot, bus, bicycle, other public transport, other private transport) to the clinic?
8. How long does it take for you to travel to the clinic from the place where you work as a sex worker? How far is it from your home?
9. Do you feel it was important to have a medical practitioner following/monitoring your illness?

GUIDE ELEVEN

Service Delivery, Continued

11. Were you seen by anyone before the health provider (i.e., receptionist, nurse, aide)?
12. What was the waiting room like?
13. Once it was your time to be seen, where did the health provider see you (i.e., private room, screened off space, open space visible to other than provider)?
14. What did the provider ask you to tell him/her (i.e., symptoms, type of illness, cause, transmission issues, partners)?
15. What did the provider tell you (probe for disease, treatment, prevention, partner notification and treatment, sexual behavior during treatment)?
16. How did you feel about the medical treatment (i.e. pills, injection or cream) that was prescribed for you? Was it sufficient for your illness?
17. Did you get any condoms while you were at the clinic? Did anyone talk to you specifically about condoms and how to use them? Did you ask them to give you condoms?
18. How would you have felt if the provider told you that he/she would help notify your partners for you if you could identify them? Would that be better or worse than telling your partners yourself? Why or why not?
19. How did you feel about using this clinic? Would you go back for service again (probe for their ideas about overall quality of the services)?
20. Did they ask you to come back to check and see if your infection was cured? How do you feel about being asked to go back for a follow-up visit like this (barriers to follow-up)?
21. What was the provider's attitude towards you? Do you feel confidentiality was maintained?
22. What changes could be made to make the clinic visit better (probe for provider attitudes, interpersonal communication, waiting room, privacy, adequacy of supplies, clinic hours, authority of service, cost of services, cost of drugs)? If you could only make one or two changes to improve the clinic, which ones do you think are the most important?
23. Are there reasons that would make it less acceptable for a man/woman (select the other gender than the respondent) to go to a clinic? Are there other kinds of people that would not want to go to that clinic (i.e. male sex workers or transvestites)?
24. Would a sex worker need permission from anyone (i.e. bar/brothel/ establishment owner, pimp, madam, administrator, boyfriend, spouse, etc) to visit a clinic?
25. If you did not go to a clinic for treatment, why did you choose not to? Did you go elsewhere for

GUIDE ELEVEN

Service Delivery, Continued

26. You have told me about a few things that make it difficult or impossible for you to go to the clinic. If any of these things could be changed, would you want to go to the clinic (eg. cost of service and/or drugs, availability of services and/or drugs, clinic hours, communication with providers, time spent to get services)? What are the most important things to change so you would be interested in going to the clinic? Why?

Part B: Registration system

27. When do you go to the clinic to renew your health certification (frequency, for symptoms or not)?

28. Do you do anything before going to the clinic (probe for douching, prophylactic antibiotic use, etc)? If so, why do you do this (probe trying to suppress symptoms)?

29. Do you get any treatments while you are in the clinic? Do you get any prescriptions for treatments? Do you have to buy the treatments yourself?

30. Do you think that the care you get when you go to the clinic is effective for your health problems?

GUIDE TWELVE

Communication

I

Interviewer Instructions: In this interview you will ask for the informant's experience related to communication about STD-related illnesses. It is assumed that you will be asking these questions of "key informants" identified through previous interviews.

Question

Q

Today I am interested in talking with you about the ways in which people learn about sexually transmitted illnesses that we've talked about during other interviews. Would you mind talking with me about this?

1. Can you tell me some of the names of sexually transmitted illnesses with which you are familiar?
2. Are some STDs more important to worry about than others? If so, why?
3. How did you learn about these illnesses (probe for different channels: people, media, print)?
4. What did you learn about how someone can get them (probe for cause, transmission)?
5. What did you learn about how to avoid getting them?
6. Do you think there is a connection between getting an STD and getting HIV? If so, what is the connection?
7. Do you think there any groups of people who are more likely to get an STD? If so, why? (probe if varies according to type of clients, type of SW, frequency of sex contacts, age, hygiene, condoms, prophylactic antibiotic use, etc)
8. What do you think are your chances of getting and STD? Why? What do you think are your chances of getting the AIDS virus? Why?
9. Are sexually transmitted illnesses a subject of conversation among people you spend time with? If yes, why? If no, why not? What kinds of people are able to talk about STD with each other?
10. Are there any sexually transmitted illnesses which are not believed to be treatable with Western medicine? If yes, why?
11. Have you ever talked with any kind of health worker about sexually transmitted illnesses? If yes, what kind of health worker have you talked to? What did he/she tell you?
12. How did you feel about this conversation(s)? What could have been better about the conversation? What could the provider have said to make your understanding more complete? What could the provider have said to make you feel he/she respected your concerns about this illness? (probe to see if different kinds of health care workers, i.e. doctor, nurse, social worker, receptionist, have

GUIDE TWELVE

Communication, Continued

13. What words do you use when you talk about sexually transmitted illnesses with your friends? Would those words be acceptable for anyone to use when talking about this subject?
14. What kinds of pictures could be used to help people like you understand about the experiences people have when they get a sexually transmitted illnesses? Are there any kinds of pictures that would be offensive?
15. If you wanted to encourage someone (interviewer: cite example "like another sex worker" or "like another man who pays for sex") to use a condom, what would you tell them?
16. If you wanted to encourage someone with an STD (interviewer: same instructions as for Question 15) to go get examined or get treatment, what would you tell them?
17. What kinds of pictures and words could be used to tell your clients about sexually transmitted illnesses? What about for the establishment owners, pimps or madams?
18. Whose advice do you trust for information about sexually transmitted illnesses? Whose advice do you not trust?
19. How would you feel about talking with your clients about sexually transmitted illnesses (e.g., about prevention, treatment, partner notification)? Is this something you could do easily? Why or why not? Is it the same for regular clients as for new clients? Do you feel that you could use some help to feel comfortable talking about this subject with your clients? What would make you feel more comfortable?
20. How would you feel about talking with your other partner (boyfriend, spouse) about sexually transmitted illnesses (e.g., about prevention, treatment, partner notification)? Is this something you could do easily? Why or why not? Do you feel that you could use some help to feel comfortable talking about this subject with your partner? What would make you feel more comfortable?